



Enhancing Military–Civilian Medical Synergies

The Role of Army Medical Practice
in Civilian Facilities

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This work is dedicated to the memory of our friend and colleague

*Michael A. Wermuth
1946–2015*

Preface

This report documents research conducted for the project “Synergies with Civilian Hospitals.” Its purpose was to identify U.S. Army Medical Department opportunities for cost savings and effectiveness improvements through synergies with civilian medical facilities.

This report describes Army medical practice in civilian facilities, including those that the U.S. Department of Veterans Affairs operates. It addresses the magnitude, nature, reasons, and mechanisms for such practice and suggests opportunities for improvement. As such, it should be of direct interest to the U.S. Army Office of the Surgeon General and U.S. Army Medical Command policymakers and managers at all levels, including regional medical commands and military treatment facilities, and, more broadly, to health leaders throughout the U.S. Department of Defense. It should also be of interest to policymakers in the Department of Veterans Affairs and to the U.S. Congress, which provides the authorities and appropriations for the broad-ranging activities of the Department of Defense.

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Summary

Introduction

The Army's Office of the Surgeon General (OTSG) and U.S. Army Medical Command (MEDCOM) oversee the staffing and operations associated with their missions to support military operations and provide care to a wide range of beneficiaries. These services require different types of medical and auxiliary personnel and are provided in both deployed and garrison environments. Army medical professionals must acquire and maintain the high level of proficiency required to fulfill the Army's medical missions. The medical care demands in a combat setting often do not mirror those in U.S. medical treatment facilities (MTFs). Further, the demands of beneficiary care sometimes outweigh the capacity of MTFs in garrison. Although the Army takes MTF capacity and beneficiary demand into account in assigning medical personnel to MTFs, MTFs sometimes enter into agreements with civilian organizations in local communities to meet shortfalls in proficiency training and to provide beneficiary care. One type of agreement allows for MTF-based care providers, mostly physicians, to provide direct care to Military Health System (MHS) beneficiaries at civilian hospitals; there are similar resource-sharing agreements with U.S. Department of Veterans Affairs (VA) medical centers; and, at some locations, Army MTFs share medical resources with other services in multiservice markets (MSMs). These arrangements are largely intended to improve the timing, quality, and efficiency of care for beneficiaries, but they also help military medical professionals maintain clinical proficiency. Yet another type of agreement, which is intended solely to enhance profi-

ciency, enables such military medical personnel to provide care to civilian patients, in a training context.

Research Objective and Methods

The Army Surgeon General asked the RAND Arroyo Center to assess current Army medical practice in civilian facilities, including those that VA operates, and suggest opportunities for greater synergies. To address these objectives, the research team reviewed relevant statutes, military guidance, and published papers. The four U.S.-based regional medical commands (RMCs) provided data from all 28 MTFs under Army command to RAND Arroyo Center.¹ The research team used those data to produce summary statistics and for analyses that drew from the full range of information sources. The research team also reviewed the structure and content of 30 agreements, including 26 identified from a cataloged list of agreements held in a MEDCOM repository and four more that were provided during one site visit. The team conducted interviews with subject-matter experts in the Army, Navy, Air Force, and Office of the Secretary of Defense to better understand the context in which agreements are created and implemented and the purposes for such agreements; determine what authorities and guidance are relevant, existing, or needed; describe how the agreements are executed; and better understand the benefits and challenges of these agreements.

Finally, the research team visited four representative MTF sites and interviewed both military health leaders and their local civilian counterparts for more in-depth review:

- Dwight D. Eisenhower Army Medical Center (AMC) at Fort Gordon, Georgia, part of Southern RMC
- Guthrie Ambulatory Health Care Clinic at Fort Drum, New York, part of Northern RMC

¹ RMCs were in effect during the study period but were subsequently changed to regional health commands, with realignment of MTFs.

- Evans Army Community Hospital (ACH) at Fort Carson, Colorado, part of Western RMC (WRMC)
- William Beaumont AMC at Fort Bliss, Texas, also part of WRMC.

Findings

The study found that management of external medical practice is largely decentralized and context-specific: Each MTF develops its own business plan, taking into account the local profile and alignment between MTF supply (assigned personnel, facilities, services), beneficiary demand (at the MTF and in the broader local catchment area), medical readiness and other training needs of MTF personnel, and cost considerations. The relevant statutes indicate that the goals of resource-sharing agreements with both the VA and non-VA civilian facilities are to provide care to beneficiaries more effectively, efficiently, and economically and, in the case of VA sharing agreements, to increase access to care. Training agreements help military professionals enhance or maintain clinical proficiency. With these foundational premises, highlights of the findings related to Army MTFs, agreements, and stakeholder interviews follow.

Information from Army Medical Treatment Facilities

Of the 28 Army parent MTFs distributed across the four U.S.-based RMCs, 13 indicated that military medical personnel under their commands, most commonly surgeons, provide care in VA or other civilian facilities, mostly at non-VA civilian facilities (Table S.1). The most frequently reported reasons are to serve beneficiaries and to meet routine proficiency maintenance needs. MTFs also offered further justifications for providing care at civilian or VA facilities; these included types of care that are not available at the MTF or when external practice serves as an incentive for retention of Army medical talent. All outside practice is through formal agreement.

Nine of the 13 MTFs reporting no external practice (in VA, non-VA civilian, or other MHS) indicated that their routine and

Table S.1
Types of Facilities, Providers, and Reasons for Care Outside an Assigned Medical Treatment Facility

MTF	Type of Facility				Service	Reason for Care
	VA	Non-VA Civilian	Affiliated MTF	Another DoD MTF		
Northern RMC	1	3	4	2		
Keller ACH, West Point, N.Y.	1	1	1		Surgery (general, orthopedics, podiatry)	Beneficiary care
Ireland ACH, Fort Knox, Ky.		1	1	1	Surgery (general) (pending)	Beneficiary care
Guthrie Ambulatory Health Care Clinic, Fort Drum, N.Y.		1			Surgery (orthopedic, obstetrics and gynecology)	Beneficiary care
Womack AMC, Fort Bragg, N.C.			1			
McDonald Army Health Center, Fort Eustis, Va.			1	1		
Kenner Army Health Clinic, Fort Lee, Va.						
Kimbrough Ambulatory Care Center, Fort George G. Meade, Md.						
Pacific RMC	0	1	0	0		
Tripler AMC, Fort Shafter, Hawaii		1			Not specified	Beneficiary care

Table S.1—Continued

MTF	Type of Facility				Service	Reason for Care
	VA	Non-VA Civilian	Affiliated MTF	Another DoD MTF		
Southern RMC	3	3	2	3		
Winn ACH, Fort Stewart, Ga.		1	1	1	Surgery (general, orthopedic)	Beneficiary care
Reynolds ACH, Fort Sill, Okla.		1			Surgery (general, orthopedic, ENT)	Beneficiary care
Dwight D. Eisenhower AMC, Fort Gordon, Ga.	1	1		x	Surgery (obstetrics and gynecology, thoracic, plastic); family medicine, neurology	Beneficiary care, routine proficiency
San Antonio Military Medical Center, Joint Base San Antonio–Fort Sam Houston, Texas	1		1	1	Surgery (thoracic, ENT)	Routine proficiency, pre-deployment
Blanchfield ACH, Fort Campbell, Ky.	1				Not specified	Beneficiary care, routine proficiency, pre-deployment
Moncrief ACH, Fort Jackson, S.C.						
Martin ACH, Fort Benning, Ga.						
Lyster Army Health Clinic, Fort Rucker, Ala.						

Table S.1—Continued

MTF	Type of Facility				Service	Reason for Care
	VA	Non-VA Civilian	Affiliated MTF	Another DoD MTF		
Fox Army Health Clinic, Redstone Arsenal, Ala.						
Carl R. Darnall AMC, Fort Hood, Texas						
Bayne-Jones ACH, Fort Polk, La.						
WRMC	1	4	0	1		
William Beaumont AMC, Fort Bliss, Texas	1	1			Surgery (general, orthopedic, ENT, obstetrics and gynecology, urology, ophthalmology)	Routine proficiency
Madigan AMC, Joint Base Lewis-McChord, Wash.		1			Surgery (obstetrics and gynecology, thoracic)	Routine proficiency, beneficiary care
Evans ACH, Fort Carson, Colo.		1		1	Surgery (urology)	Routine proficiency
Bassett ACH, Fort Wainwright, Alaska		1			Surgery (general); family medicine, internal medicine, psychiatry	Routine proficiency
Weed ACH, Fort Irwin, Calif.						

Table S.1—Continued

MTF	Type of Facility				Service	Reason for Care
	VA	Non-VA Civilian	Affiliated MTF	Another DoD MTF		
Raymond W. Bliss Army Health Center, Fort Huachuca, Ariz.						
Munson Army Health Center, Fort Leavenworth, Kan.						
Irwin ACH, Fort Riley, Kan.						
General Leonard Wood ACH, Fort Leonard Wood, Mo.						
Total (<i>n</i> = 28)	5	11	6	6		

NOTE: DoD = U.S. Department of Defense. ENT = ear, nose, and throat.

deployment-related medical readiness needs were met at the MTF; the four others did not specify a reason, although one indicated that it had sent personnel to the local VA medical center in the past and was developing a new agreement to do so again.

At the time of the data call to request information from MTFs, discussion with OTSG staff and review of documents and published papers had indicated that training for medical readiness needs, especially deployment-related needs, was likely to be the major reason for outside practice; there was little indication at that time that external practice to provide beneficiary care would prove to be as prevalent as it was. The data request had not specifically solicited information on the MTFs' assessments of the alignment between MTF capacity and local beneficiary needs or whether the MTF had consciously considered the potential need to send professionals to provide beneficiary care in a local civilian facility. No MTF backfilled staff during their time away.

Information from Review of Agreements

The team reviewed 30 relevant agreements that were available from the repository or site visits (Table S.2). Nearly all MTFs that reported any kind of external medical practice reported external resource-sharing agreements (ERSAs), which cover beneficiary care by military providers in civilian facilities. Far fewer reported VA–DoD sharing agreements (which cover military providers in VA facilities or vice versa); gratuitous

Table S.2
Different Types of Agreement Identified and Available for Review

Type of Agreement	Number Available from Repository or Site Visit	Number Reported by MTF but Not Available from Repository or Site Visit	Total
ERSA	19	11	30
VA–DoD	2	4	6
GTA	8	0	8
MOA	1	0	1
Total	30	15	45

training agreements (GTAs), which cover training; or memoranda of agreement (MOAs), which do not specifically commit resources.

The 19 ERSAs we reviewed did not follow a standard format, and the information contained in them was not uniform. For example, only six of them provided information on the type and specialty of provider that the agreements included; most were more general in nature, not specifying the type or specialty of personnel. Both ERSAs and the one MOA specified inpatient or outpatient services in general terms, while the GTAs were more specific and standardized. During the four site visits, interviewees reported preferring generic agreements (referring mostly to ERSAs) that cover a broad spectrum of opportunities and provider types rather than an agreement that specifies providers by name or specialty, which could become outdated more quickly. All agreements had clear statements on statutory or DoD authorities, responsibility of parties, term of agreement, liability coverage provisions, and funding. VA–DoD resource-sharing agreements and GTAs were the most standardized and complete types of agreement.

Finally, although we found generally good correlation between agreements in the central MEDCOM repository and those that the MTFs reported, not all reported agreements are in the MEDCOM repository, and there is some evidence that MTFs' reporting of agreements was incomplete.

Themes from Stakeholder Discussions, Including Site Visits

Our analysis of the stakeholder interviews and the four site visits resulted in the categorization of findings into common themes, including the benefits and challenges of Army medical practice in VA and non-VA civilian facilities. Although the MTFs find the guidance for such agreements to be outdated, insufficient, and in need of updating, MTFs that use one or more types of agreement for medical practice outside their MTFs (which were mostly ERSAs for providing beneficiary care) and the counterpart civilian institutions universally find such arrangements mutually beneficial. Both military and civilian stakeholders cite many dimensions of benefit, including access, quality, and continuity of care they can provide to MHS beneficiaries; opportunities for Army medical practitioners to be exposed to industry best practices in civilian

facilities; and access to sophisticated medical technologies that might not be available or justifiable in the MTF and are more productively used in civilian facilities. Military personnel cite good community relations as another benefit.

Most current Army medical practice outside MTFs involves *physicians* (mostly surgeons) who, usually as *individuals* rather than as part of a team, provide care to beneficiaries. Very few agreements involve nurses, medical technicians, or other medical personnel. However, in at least one location that already uses ERSAs extensively for physicians, both MTF personnel and their civilian counterparts indicated that they had not given sufficient thought to enlarging the range of Army medical personnel who take advantage of opportunities to provide beneficiary care in the civilian facility but that they intend to consider such expansion in their future planning. Related to this is their indication that expansion of types of personnel might also include their participation in such agreements as teams, rather than just as individuals.

Stakeholders cited only a few challenges to such agreements. Given the attention to liability considerations and the U.S. Department of Justice rulings documented in materials reviewed, we had anticipated that malpractice liability, as well as credentialing of physicians in a local civilian hospital, might pose challenges; however, as various stakeholders reported, credentialing does not appear to pose a major barrier, nor do liability issues, because the Army has provided Department of Justice–approved standard language for liability coverage for the major types of agreement. One of the greatest challenges is the lack of interoperability of patient medical records across systems, both MTF–VA and MTF–civilian, which creates inefficiencies, including delays in care delivery and time-consuming manual transfer of patient information. Still, some sites are creating workarounds to address these issues. Systemic fixes that apply more broadly, within a local area or even across the country, would be highly desirable. The Army can leverage ongoing efforts, which mostly aim to standardize electronic health records across the MHS, to address these challenges in the future.

Another perceived challenge raised at one site and in other interviews is the lack of uniformity of clinical care standards and proce-

dures between DoD and VA. However, at that one site, both MTF and VA personnel interviewed noted that they recognized this and are working to standardize these satisfactorily, upward through the chain of command on each side.

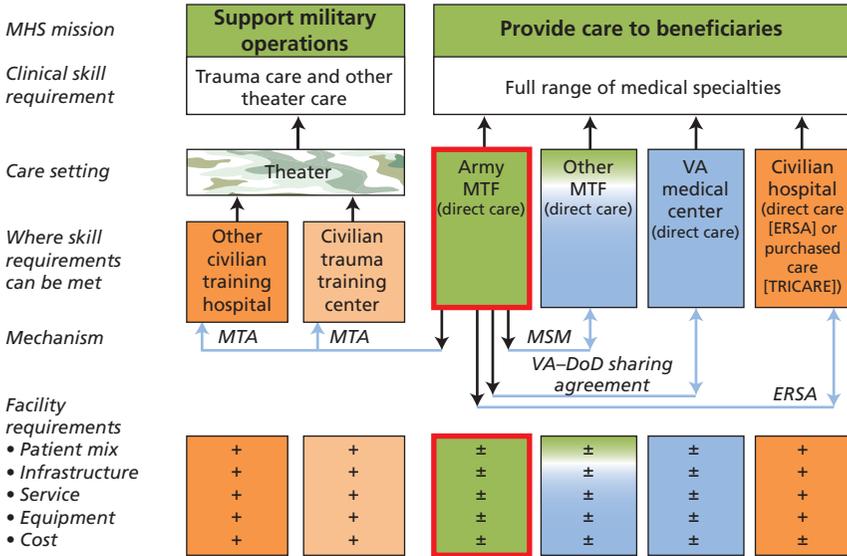
An administrative challenge is clarifying who gets “credit” (for TRICARE reimbursement and productivity monitoring purposes) for care that military practitioners provide in facilities outside MHS.

Conclusions and Recommendations

MHS continues to enhance the efficiency and quality of care to meet its two missions of supporting military operations and providing beneficiary care and to meet its four aims of readiness, population health, experience of care, and cost of care. In doing so, it grapples with balancing direct and purchased care. Although Defense Health Agency policy is increasingly oriented toward “recapturing” beneficiaries for care within MTFs, different types of agreements enable some degree of direct care outside Army MTFs, in facilities that might be better equipped to both serve beneficiaries and offer opportunities to maintain clinical proficiency—in the MTFs of other services (in the enhanced MSMs), in VA medical centers (through VA–DoD sharing agreements), and in non-VA civilian facilities (through ERSAs). Other types of agreement are intended to provide training, whether for purposes of deployment or routine maintenance of clinical skills. Planners at each MTF develop their business plans taking into account (1) the local supply (the personnel and volume and types of capacity and care available at the MTF and at other local facilities, including other MTFs, other federal facilities, and non-VA civilian facilities); (2) the local beneficiary demand at the MTF and in its broader local catchment area; (3) MTF medical personnel needs for training; and (4) cost considerations.

Figure S.1 summarizes the MTF business planning landscape (MTFs’ centrality is indicated by the bold red outline in the figure): the clinical skill requirements to meet the MHS missions, the care settings in which those requirements could be met, the mechanisms that

Figure S.1
Factors Guiding Army Medical Treatment Facility Decisions Regarding External Practice



NOTE: + = adequately meets requirements. ± = might or might not meet requirements. MTA = medical training agreement.

RAND RR1313-S.1

Army MTFs can use to access those settings, and the requirements for such facilities (patient mix, infrastructure, services available, equipment, and cost optimization). All of these contribute to MTFs’ decisions about where and how they can best meet their various mission-related requirements. For example, civilian hospitals, including trauma training centers, typically have adequate patient mixes in terms of numbers and complexity; infrastructure (e.g., operating room, intensive care); services available (e.g., emergency, obstetric delivery, inpatient); and equipment (e.g., diagnostic, surgical), all reflected as “+” in the figure. For GTAs with civilian facilities, cost considerations are also favorable (such agreements involve no exchange of funds). Each Army MTF might or might not meet the full complement of facility requirements—reflected as “±” in the figure. An MTF that can meet all needs within the MTF might not need to seek civilian partnerships.

However, those that lack critical features might need to meet shortfalls through one or more mechanisms described in this report. Their choices of partners will depend on the presence and characteristics of other local facilities, as well as cost considerations.

MTF resource utilization and decisions about sending medical personnel outside the assigned MTF are determined at the MTF level, as described above. The most commonly reported type of external practice was through external and VA resource-sharing agreements, which enhance access, quality, and continuity of beneficiary care, and are perceived as cost saving (to TRICARE, for provider costs in non-VA facilities), while also exposing military providers to industry (civilian) best medical practices in such facilities and helping them maintain their technical proficiency. Thirteen of 28 Army MTFs reported one or more professionals who provide care under such arrangements—mostly physicians and, among them, mostly surgeons. MTF personnel and their counterparts at the four sites visited universally consider such agreements mutually beneficial, including multiple specific benefits to the Army.

Although most of the 15 MTFs that did not report such practice indicated that their *routine and deployment-related medical readiness needs* were met at their MTFs, we did not ask them specifically about their assessments of the alignment between MTF capacity and *beneficiary needs* beyond those that can be met at the MTF, and therefore about any need for resource-sharing agreements to address the latter. Moreover, we did not specifically ask the 13 MTFs that do engage in such agreements about whether they had considered the need to extend external practice to disciplines beyond physicians.

As noted above, MTFs that use one or more types of agreement for medical practice outside their MTFs and the counterpart institutions universally find such arrangements mutually beneficial. They cite as benefits the better access, quality, and continuity of care they can provide to military beneficiaries and opportunities for Army medical practitioners to be exposed to industry best practices in civilian facilities and have access to sophisticated medical technologies that might not be available or justifiable in the MTFs. They note also that such agreements contribute to good community relations. The benefits and

broad acclaim that the parties accord to such agreements suggest that any untapped opportunities should be identified and that an MTF should be encouraged to take advantage of them if they are justified in the MTF's business plan. Thus, this report sets the qualitative foundation for more-focused analysis in this direction, including a thorough economic analysis that takes opportunity costs into account, as well as more easily documented costs to TRICARE and MHS as a whole.

Regardless of the magnitude of any untapped opportunities, the guidance documents for two important types of agreement (ERSAs and GTAs) warrant updating because they are outdated and less than comprehensive. Even MTFs that already use these mechanisms noted the insufficiency of current guidance and recommended updating. We found limited guidance for ERSAs. The OTSG/MEDCOM memo originally issued as policy memorandum 14-059 in July 2014 (Fiore, 2014) and most recently reissued as policy memorandum 15-022 in April 2015 (Fiore, 2015) updates the guidance for VA–DoD sharing agreements; this memo might be a good model for updating guidance on these other agreements and might, thus, help to raise attention about such agreements (and the use of them) across more of the Army medical community.

Stakeholders did identify some challenges associated with external medical practice, such as the lack of interoperability of patient medical records across systems and the lack of uniformity of clinical care standards and procedures across systems that share medical resources.

The conditions that favor Army medical practice outside the assigned MTF appear to derive mainly from the local profile and alignment between each MTF's supply (of assigned personnel and available facilities and services), local beneficiary demand (at the MTF and in its broader catchment area), training needs of MTF personnel, and cost considerations that might favor (or at least do not disfavor) such practice. The MTFs that use ERSAs do so when they have excess personnel capacity that can help meet local beneficiary demand that cannot be met at the MTF, such as when facility space (such as operating room or intensive care unit), medical service (such as obstetric delivery), or a specific technology (such as robotic surgery apparatus), is not available at the MTF. All 13 MTFs use resource-sharing agreements mostly for

physicians and, among them, mostly for surgeons across multiple surgical specialties. This is not surprising because surgical practice tends to have facility and technology requirements that might not be available (or justifiable) at the MTF, which are more complex than what the practice of many non-surgical specialties requires. MTFs enter into resource-sharing agreements with local VA medical centers when a business case analysis on both sides justifies the mutual benefits, such as reducing VA patient backlog in medical specialties for which MTF volume and mix are insufficient for the number of providers. We conclude that military and civilian users and leaders share strong consensus regarding the benefits of external medical practice and that such practice is warranted when the MTF and partner institution can justify a military–civilian agreement in their respective business plans.

These conclusions suggest some recommendations for enhancing military–civilian medical synergies:

1. Update OTSG/MEDCOM policy guidance for ERSAs and GTAs.
2. Identify appropriate proponents for ERSAs and for GTAs.
3. In the short term, identify potential untapped opportunities for external practice, especially ERSAs, and encourage their use when justifiable in MTF business plans.
4. For longer-term policy purposes, conduct a quantitative assessment of the costs and potential efficiencies associated with care provided in MHS compared with different civilian options, such as those examined in this initial qualitative study.
5. If warranted following such analysis, encourage the expansion of agreements to include a wider range of Army medical professionals and medical teams.
6. Maintain the current decentralized management scheme, but consider a mechanism for central visibility of agreements.
7. Facilitate mechanisms to share experiences and learn lessons about different types of sharing and training agreements.

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Abbreviations

ACH	Army community hospital
AMC	Army medical center
AOC	area of concentration
BAMC	Brooke Army Medical Center
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CONOPS	concept of operations
DDEAMC	Dwight D. Eisenhower Army Medical Center
DHA	Defense Health Agency
DoD	U.S. Department of Defense
DoDI	Department of Defense instruction
eMSM	enhanced multiservice market
ENT	ear, nose, and throat
ERSA	external resource-sharing agreement
FST	forward surgical team
FY	fiscal year
GAHC	Guthrie Ambulatory Health Care Clinic

GAO	U.S. Government Accountability Office
GME	graduate medical education
GTA	gratuitous training agreement
IT	information technology
JBLM	Joint Base Lewis-McChord
JBSA	Joint Base San Antonio
MEDCOM	U.S. Army Medical Command
MHS	Military Health System
MOA	memorandum of agreement
MSM	multiservice market
MTA	medical training agreement
MTF	medical treatment facility
NRMC	Northern Regional Medical Command
OSD	Office of the Secretary of Defense
OTSG	Office of the Surgeon General
PRMC	Pacific Regional Medical Command
RMC	regional medical command
SAMMC	San Antonio Military Medical Center
SRMC	Southern Regional Medical Command
TAA	training affiliation agreement
TAMC	Tripler Army Medical Center
VA	U.S. Department of Veterans Affairs
WBAMC	William Beaumont Army Medical Center
WRMC	Western Regional Medical Command

Introduction

Background

The U.S. Army Office of the Surgeon General (OTSG) and U.S. Army Medical Command (MEDCOM) oversee the staffing and operations associated with their medical missions to support military operations and provide care to a wide range of beneficiaries.¹ These services require different types of medical and auxiliary personnel and are provided in both theater and garrison. Army medical professionals must acquire and maintain the high level of proficiency required to fulfill the Army's medical missions.

The medical care demands in a combat setting often do not mirror those in U.S. military treatment facilities (MTFs). Further, the demands of beneficiary care sometimes outweigh the capacity of MTFs in garrison. Although the Army takes MTF capacity and beneficiary demand into account in assigning medical personnel to MTFs, MTFs sometimes need to find ways to meet shortfalls in proficiency training and beneficiary care.

This raises some questions. How do Army medical professionals maintain the proficiency needed for routine recertification and deployment? How are shortfalls in the capacity to treat eligible beneficiaries addressed? To address these questions, military medical professionals have provided care to beneficiaries outside their assigned MTFs at U.S. Department of Veterans Affairs (VA) and other civilian facilities. Several mechanisms allow for medical practice outside the Military Health

¹ For a complete listing of beneficiaries, see Chapter Two.

System (MHS), each with its own specified goals and requirements. These agreements are used primarily in MTF catchment areas where the MTF capacity—primarily facilities and equipment—is insufficient to meet beneficiary demand, where access to care and continuity of care might be provided more efficiently and effectively outside the MTF, and where MTF specialty physicians require external supplements to their MTF patient case loads and mixes to enhance or maintain clinical proficiency, and they are available to provide services outside their assigned MTFs without limiting MTF operations. The agreements also are intended help VA treat its beneficiary population in a more efficient and timely manner and promote a local medical community of professionals for each region in which such agreements are enacted.

OTSG asked RAND Arroyo Center to explore these agreements and their implementation to see how much and why they are called on and what benefits are afforded to military medical professionals and beneficiaries. Further, OTSG asked the center to focus on activities other than those associated with graduate medical education (GME) (e.g., initial physician training—medical school, residency, and fellowship training) because a senior Army official had advised that the role and relationship between the Army and civilian institutions for GME purposes had already been well studied.

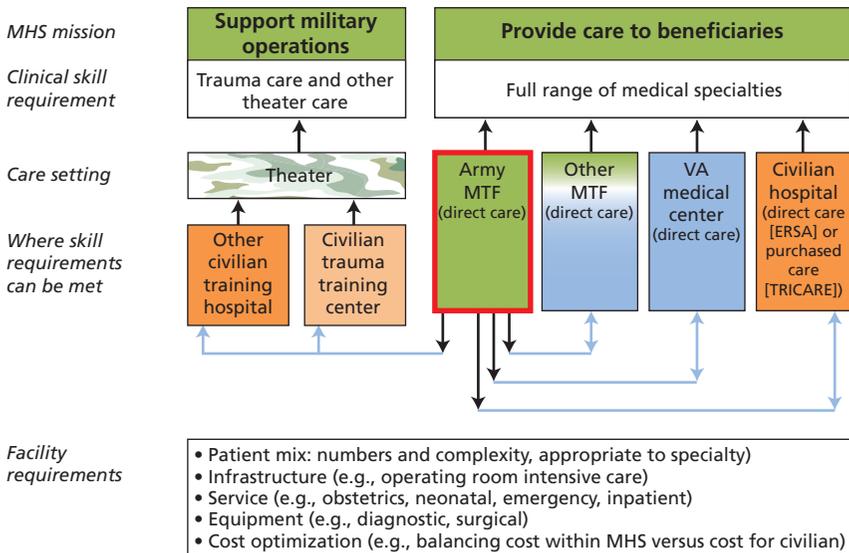
Study Objective

The objective of this study was to identify OTSG and MEDCOM opportunities for cost savings and effectiveness improvements through synergies with civilian medical facilities, including VA. This report addresses the magnitude, nature, reasons, authorities, mechanisms, and perceived benefits and challenges associated with such practice, and it suggests opportunities for enhanced military–civilian medical synergies. This initial exploratory assessment aimed to set a qualitative foundation for quantitative analysis to support longer-term policy development.

Methods

To address the study objective, the research team reviewed published documents and collected information from three additional complementary sources: a data call to MTFs, review of individual agreements, and consultations with stakeholders at both headquarters level and military and civilian health providers at four selected MTF sites. Figure 1.1 is a conceptual framework that captures the context within which Army MTFs make decisions about where and how they can best meet their mission-related requirements and the range of external partnerships we examined in this study. Early review of policy documents and discussions with OTSG suggested that, when an Army MTF cannot meet all clinical skill requirements within the MTF to fulfill its medical mission, it might draw on other care settings. Reasons might

Figure 1.1
Conceptual Framework Guiding Army Medical Treatment Facility Decisions Regarding External Practice



NOTE: ERSA = external resource-sharing agreement.

include insufficient MTF patient mix, infrastructure, service availability, or equipment.

Information from Medical Treatment Facilities

The team first sought information on all Army-managed MTFs as an initial way to understand the range of settings from which certain professionals worked in VA or other civilian facilities. The team consulted public-access documents, such as relevant statutes, U.S. Department of Defense (DoD) and Army guidance, and journal papers, as well as each MTF’s website. However, these sources provided only some of the desired information and generally did not include information about the nature, magnitude, or reasons for Army professionals practicing in civilian facilities. Therefore, in July 2014, the Army’s Deputy Surgeon General tasked the four U.S.-based Regional Medical Commands (RMCs) to manage the collection of data from the 28 MTFs under Army command.² The RMCs returned completed questionnaires for all 28 MTFs (100-percent response rate). The questionnaires did not ask the position of the people at the MTFs who provided the information. The study team used responses to the questions in Table 1.1 to

Table 1.1
Questions in the Medical Treatment Facility Data Call

Number	Question
1–4	MTF identifying information
5	Do any military medical personnel under this MTF’s command provide care outside the assigned MTF as part of their official duties?
6.1	IF NO to #5, <i>because</i> : Routine and deployment-related medical readiness needs are met at assigned MTF
6.2	IF NO to #5, <i>because</i> : Needs not met at assigned MTF are met at a DoD training facility/center
6.3	IF NO to #5, <i>because</i> : Another reason
7.1	Outside care provided at: An affiliated MTF

² RMCs were in effect during the study period but were subsequently changed to regional health commands, with realignment of MTFs.

Table 1.1—Continued

Number	Question
7.2	Outside care provided at: Another Defense Health Program MTF
7.3	Outside care provided at: A Veterans Health Administration facility
7.4	Outside care provided at: A non-VA civilian health facility
7.5	Outside care provided at: How many different VA or other civilian facilities?
8.1	Outside care provided under what authority/authorities?
8.2	For care provided at VA or other civilian facility: Is there a formal agreement?
8.3	IF YES to #8.1: With how many different facilities?
8.4	IF NO to #8.1: Is there another mechanism supporting practice of military medical personnel in VA or other civilian facility?
9.1	A reason for care provided at VA or other civilian facility = to meet ROUTINE proficiency needs
9.2	A reason for care provided at VA or other civilian facility = to meet PRE-DEPLOYMENT proficiency needs
9.3	A reason for care provided at VA or other civilian facility = to meet POST-DEPLOYMENT proficiency/reintegration needs
9.4	A reason for care provided at VA or other civilian facility = to serve local military beneficiaries, in the absence (or inadequacy) of the service at the MTF
9.5	A reason for care provided at VA or other civilian facility = other
10.1	Medical personnel providing care in VA or other civilian facility do so in their capacity as: INDIVIDUALS
10.2	Medical personnel providing care in VA or other civilian facility do so in their capacity as: TEAMS
11.1	Name of VA or other civilian facility
11.2	DMIS ID of VA or other civilian facility
11.3	Is the VA or other civilian facility affiliated with a medical school?
12.1	Is there an exchange of funds for military medical practice in VA or other civilian facility?
12.2	If YES to #12.1: DoD provides funding to VA/other facility

Table 1.1—Continued

Number	Question
12.3	If YES to #12.1: VA/other facility provides funding to DoD
12.4	Does DoD/Army provide malpractice/liability coverage for military medical personnel care in these facilities?
13	Initial year of current agreement
14.1	A justification for military practice in VA/other facility = Service is not provided at the MTF
14.2	A justification for military practice in VA/other facility = Service is provided at the MTF, but insufficient patient volume or mix
14.3	A justification for military practice in VA/other facility = Service is provided at the MTF, but insufficient auxiliary staff
14.4	A justification for military practice in VA/other facility = incentive for retention of talented Army medical personnel
14.5	IF YES to #14.4, what type of personnel practice in a VA or other civilian facility as an incentive for their retention in the military?
14.6	A justification for military practice in VA/other facility = other (not covered by #14.1–14.4)
15.1	Time away from MTF for civilian practice: Total person-days in the past 12 months (or per year on average)
15.2	Time away from MTF for civilian practice: Number of times per year away from MTF
15.3	Time away from MTF for civilian practice: Duration (days) away from MTF each training/agreement period
15.4	When medical personnel are away from MTF to provide services at VA/ other civilian facility, are they back-filled?
16.1	Number of personnel practicing in VA/other civilian facility: Medical Corps
16.2	Medical Corps—Skill type and suffix
16.3	Number of personnel practicing in VA/other civilian facility: Specialty Corps
16.4	Specialty Corps—Skill type and suffix
16.5	Number of personnel practicing in VA/other civilian facility: Nurse Corps
16.6	Nurse Corps—Skill type and suffix

Table 1.1—Continued

Number	Question
16.7	Number of personnel practicing in VA/other civilian facility: Medical Service Corps
16.8	Areas of Concentration (AOC) of all personnel practicing in VA/other civilian facility
16.9	Number of civilian or enlisted staff from MTF obtaining training or providing care in VA/other civilian facility

NOTE: DMIS = Defense Medical Information System. ID = identifier. AOC = area of concentration.

produce summary statistics and in subsequent analyses that drew from all information sources.

Information from Agreements

The project team reviewed 30 relevant agreements. Most of these came from a repository of agreements held by MEDCOM: Three team members independently reviewed a cataloged list of approximately 3,400 agreements held in the repository and, excluding those that were clearly related to GME or non-clinical services, identified 63 that might be relevant to the present study. After reviewing the content of those 63 agreements, they found 26 that were relevant. Four additional agreements were provided during one of the team's site visits. Thirty agreements were reported through the MTF data call, including 15 that were in the repository and 15 that were not; the data-call process had not included a request for copies of the agreements.

Information from Stakeholder Consultations

Following the data call and review of agreements and in consultation with OTSG staff, we identified subject-matter experts in the Army, Navy, Air Force, and Office of the Secretary of Defense (OSD) who are involved in agreement oversight and implementation. (Appendix A lists the offices of those interviewed.) We conducted semistructured interviews with them to discuss the different types of military medical practice in civilian facilities. Our discussions were designed to better understand the context in which agreements are created and implemented

and their purposes; determine what authorities and guidance are relevant, existing, or needed; describe how the agreements are executed; and better understand the benefits and challenges of these agreements. Depending on the role and position of the interviewee, we asked the following types of questions:

- professional background
- with regard to agreements or arrangements for civilian practice:
 - interviewee’s familiarity with them
 - background and purposes—why such arrangements exist
 - authorities
 - perceived prevalence
 - personnel and cost-related implications
 - interviewee’s views about such practice or agreements
 - benefits to the military (e.g., serving beneficiaries) or to the civilian facility
 - challenges (e.g., credentialing, liability coverage, military staff retention)
- whether the interviewee perceived any policy to be deficient or lacking
- anything else the interviewee wished to add.

Finally, drawing mainly from review of MTF data and agreements, we used several criteria to identify an appropriate mix of sites for more in-depth review with stakeholders. Our goal was to reflect a range of regions; center types (medical center, community hospital, health center); civilian facilities (VA and non-VA); reasons for practice outside the assigned MTF; professional types and specialties; and individual or team practice in such facilities. In addition, we sought a mix of MTFs for which we found agreements in the MEDCOM repository

or that the MTF reported.³ Using these criteria, we chose four sites to glean further details and visited them on the following dates:

- Dwight D. Eisenhower Army Medical Center (DDEAMC) at Fort Gordon, Georgia, part of Southern RMC (SRMC): December 9–10, 2014
- Guthrie Army Ambulatory Health Care Clinic (GAHC) at Fort Drum, New York, part of Northern RMC (NRMC): January 7–8, 2015 (when we arrived, Fort Drum was closed because of a snow emergency; we subsequently conducted all planned interviews by phone between January 14 and 30)
- Evans Army Community Hospital (ACH) at Fort Carson, Colorado, part of Western RMC (WRMC): January 20–21, 2015
- William Beaumont AMC (WBAMC) at Fort Bliss, Texas, also part of WRMC: January 27–28, 2015.

During these visits, the team met with leaders and practitioners from the Army MTF and leaders from VA facilities and from one or more civilian hospitals where MTF professionals provide care. The number of people consulted varied at each site but generally included at least ten to 20 military personnel and one or more leaders in each of the local civilian or VA facilities where Army personnel provide care. We asked questions very similar to those described above for our discussions with subject-matter experts. We also asked about specific agreements and practitioners involved in them, and we met with some of these practitioners. At the one site with both Army and Air Force MTFs (sites with MTFs from different military services are known as multiservice markets, or MSMs), we also met with Air Force MTF leaders. In each case, we asked the individual practitioners about their experiences with local medical practice outside their assigned MTFs.

³ We did not visit any site for which the MTF had reported no external practice or for which we found no agreement in the MEDCOM repository.

Organization of the Report

In the chapters that follow, we describe the history and authorities for military medical practice in VA and non-VA civilian facilities (Chapter Two), findings related to Army MTFs (Chapter Three), types of agreement and review of selected agreements (Chapter Four), findings from stakeholder discussions (Chapter Five), and conclusions and recommendations from our analyses (Chapter Six).

The appendixes include the organizations consulted (Appendix A); two relevant guidance memoranda, one issued in April 2015 (Appendix B), superseding an OTSG/MEDCOM memo originally issued in 2014, and the other issued by OTSG in 2000 (Appendix C); and detailed tables from the MTF data call (Appendix D).

History and Authorities for External Medical Care and Training

MHS is crucial to the combat readiness of U.S. service personnel. However, beyond providing combat medical care, the medical military mission grew several decades ago to encompass additional “beneficiary care.” The beneficiary cohort is now extensive. Unless otherwise specified, in this report, we use the term *beneficiary* or *MHS beneficiary* to refer to this broad range of people that MHS serves (see TRICARE, 2014):

- **uniformed service members**, which includes active component and retired members of
 - the U.S. Army
 - the U.S. Air Force
 - the U.S. Navy
 - the U.S. Marine Corps
 - the U.S. Coast Guard
 - U.S. Public Health Service Commissioned Corps
 - National Oceanic and Atmospheric Administration Commissioned Corps
 - and their families
- **National Guard and reserve members**, which includes members of
 - the U.S. Army National Guard
 - the U.S. Army Reserve
 - the U.S. Navy Reserve
 - the U.S. Marine Corps Forces Reserve
 - the Air National Guard

- the U.S. Air Force Reserve
- the U.S. Coast Guard Reserve
- and their families
- **survivors**
- **former spouses**
- **Medal of Honor recipients and their families**
- others registered in the Defense Enrollment Eligibility Reporting System.

History

Historically, the treatment of non–active-duty personnel and dependents varied across services and MTFs. Congress codified this ad hoc care system in 1956 with the Dependents’ Medical Care Act (Pub. L. 84-569), which allowed all beneficiaries to seek care at MTFs. Because the population of eligible beneficiaries quickly outpaced existing MTF treatment capacity, Congress passed the Military Medical Benefits Amendments in 1966 (Pub. L. 89-614), allowing the military to contract civilian providers to provide care to non–active-duty beneficiaries.¹ Beneficiaries previously knew this program, legally named the Civilian Health and Medical Program of the Uniformed Services, as CHAMPUS.

In 1993, DoD announced plans for restructuring the entire MHS program, including CHAMPUS. The restructured program, known as TRICARE, became operational in the late 1990s. To implement and administer TRICARE, DoD reorganized the military delivery system into 12 joint-service regions (see U.S. General Accounting Office, 1995).

MHS is one of the largest health care systems in the United States (Table 2.1). The beneficiary population receives care through three primary mechanisms: (1) direct care provided at DoD’s MTFs, (2) direct care provided at VA health facilities, and (3) purchased care provided at civilian facilities and paid through the TRICARE program (MHS,

¹ For details, see Dolfini-Reed and Jebo, 2000.

Table 2.1
Overview of the Military Health System, Fiscal Year 2014

Category	Total	Details
Beneficiaries	9.7 million	Active-duty service members and dependents: 36.7% ^a Eligible National Guard and reserve service members and dependents: 9.5% Retirees and dependents or survivors: 53.8%
MHS facilities (direct care)	666 ^b	56 hospitals 361 ambulatory care clinics 249 dental clinics
Budget (FY 2014 request)	\$33 billion	Corresponds to roughly \$3,400 per beneficiary per year

NOTE: FY = fiscal year.

^a See U.S. Government Accountability Office (GAO), 2012a.

^b MHS, 2014.

2014). Most active-duty members must seek treatment at MTFs. Beneficiaries, such as dependents and retirees, may seek care at MTFs or civilian facilities following a series of complex rules (see Jansen, 2014). One recent estimate concludes that, as of December 2014, only 25 percent of eligible beneficiaries actively sought and received their care from the MTFs, with the rest receiving care from TRICARE providers (Defense Health Agency [DHA] and MHS, 2014).

Because the budget requests for DoD health care have grown more quickly than historical growth rates of civilian health care costs, DoD leadership has focused continuously on improving the cost efficiency of the military health care system (GAO, 2013). In 1988, DoD implemented an initiative called Project Restore to address rising health care costs, the basic premise of which, according to the DoD Inspector General, was that, “in some cases, health care services could be provided more cost effectively within military health care facilities than through the use of CHAMPUS in civilian facilities” (DoD, 1992). To facilitate the “recapture” of patients by military health personnel, the project authorized two types of partnerships with civilian facilities: external and internal. External partnerships allowed military doctors to practice in civilian facilities—both VA and non-VA; in internal partnerships,

civilian doctors were permitted to practice in MTFs, through contracts or as General Service (civilian) employees, to provide care to eligible beneficiaries.² By implementing a mechanism that facilitated changes over time in the MHS infrastructure or staff in response to demand for care, the intent was to make these arrangements flexible and adaptive to optimize medical resources and manpower within a geographic area.

Legal Authorities and Department of Defense Policy Guidance for Military–Civilian Agreements

With few exceptions, military medical providers are authorized to work in VA or non-VA civilian facilities only to provide care to beneficiaries or to maintain or enhance their skills through training. In this report, we examine two principal categories of activities, for which a basic understanding of the underlying authorities and policy guidance is important. The first category is the resource-sharing arrangements for personnel and facilities with VA. The second category covers applicable arrangements with all other civilian medical care and treatment entities, both non-federal government and private organizations. Agreements in the latter category are established in various forms: ERSAs; gratuitous training agreements (GTAs), many of which are known as medical training agreements (MTAs); and memoranda of agreement (MOAs) and memoranda of understanding between the MTF and local civilian medical facilities. Although they are not directly relevant to military medical practice outside an MTF, we also make note of training affiliation agreements (TAAs) for the sake of completeness.

Resource Sharing with the Department of Veterans Affairs

In companion measures in Title 38 and Title 10 of the U.S. Code, there is fairly straightforward statutory authority for military medical cooperative arrangements with VA. These arrangements have as their goal “improving the access to, and quality and cost effectiveness of,

² These internal arrangements were not part of the scope of this study, and we do not address them elsewhere in this report.

the health care provided by the Veterans Health Administration and the Military Health System to the beneficiaries of both Departments” (38 U.S.C. 8111; 10 U.S.C. 1104).³ DoD Instruction (DoDI) 6010.23, *DoD and Department of Veterans Affairs (VA) Health Care Resource Sharing Program*, provides a comprehensive guide to these arrangements (Under Secretary of Defense for Personnel and Readiness, 2013b).

Derived from DoDI 6010.23 is the Army’s specific, detailed guidance for Army medical care and treatment facilities for cooperative arrangements with VA entities. The original guidance was issued as OTSG/MEDCOM policy memo 14-059 (Fiore, 2014);⁴ OTSG/MEDCOM policy memo 15-022 (Fiore, 2015) (see Appendix B) superseded previous versions of the policy guidance (including another updated version issued in March 2015). This document designates the U.S. Army Medical Department DoD/VA Program Office, Health Care Delivery, MEDCOM G3/5/7 as the proponent. It places principal responsibility on the MTF to develop the proposal, concept of operations (CONOPS), and business case analysis for a local resource-sharing agreement with the VA facility; designates the RMC as the preliminary approval authority and the signatory party on the final agreement once the Deputy Surgeon General approves it; and describes the review and approval processes that the program office will coordinate. The memo (both the original and the updated version) indicates that the RMCs must maintain a database of all current and expired agreements that can support queries based on specified criteria. The updated memo (15-022) provides a template for the CONOPS; several of the specified items were previously labeled (in OTSG/MEDCOM memo 14-059) as required elements in the agreements themselves.

³ U.S. Code Title 31, Section 1535, provides the basic authority for payments for such services between agencies of the federal government.

⁴ Interestingly, this policy memo cited a previous (2005) version of DoDI 6010.23, rather than the more current (2012) version noted above.

Resource Sharing with Other Civilian Institutions

There is broad, general statutory authority for establishing resource-sharing agreements between organizations in DoD and civilian health care providers. Section 1096 of Title 10, U.S. Code, says,

The Secretary of Defense may enter into an agreement providing for the sharing of resources between facilities of the uniformed services and facilities of a civilian health care provider . . . if the Secretary determines that such an agreement would result in the delivery of health care to which covered beneficiaries are entitled under this chapter in a more effective, efficient, or economical manner. (10 U.S.C. 1096[a])⁵

There are various additional statutory provisions that generally provide authority for agreements with civilian entities to create opportunities for military medical professionals to provide care to eligible MHS beneficiaries or to engage in medical training in civilian facilities. Of note, many GTAs (for Army personnel in civilian training institutions) and most TAAs (for students from civilian training institutions at MTFs) relate to GME, which pertains to medical school and physician residency training; as noted elsewhere, GME was not an area of focus in the current study. We therefore limit the discussion of authorities and policy guidance in this subsection to mechanisms for Army medical personnel to care for eligible beneficiaries outside the MTF and non-GME continuing education and training for the full range of military medical professionals—proficiency and skill maintenance training, including any requirements for specialized pre-deployment and post-deployment training, and support activities. In the rest of this section, we describe the various mechanisms of interest in more detail.

Activities authorized under these various provisions include support and services to certain designated eligible organizations and activities outside DoD that meet certain criteria. Those activities can include support and services to government and non-governmental

⁵ Paragraph (b) of that section goes on to list the “eligible” resources that may be shared as (1) personnel (including support personnel), (2) equipment, (3) supplies, and (4) any other items or facilities necessary for the provision of health care services.

entities under the condition that, for individual service members, they will “involve tasks directly related to the specific military occupational specialty of the member” (10 U.S.C. 2012). Specific DoD guidance and direction for implementing these statutory provisions are designed to establish “innovative readiness training” while continuing a long-standing Army tradition of “acting as good neighbors at the local level in applying military personnel to assist worthy civic and community needs” (Assistant Secretary of Defense for Reserve Affairs, 2004).

Another section of Title 10 generally authorizes agreements between DoD and a variety of entities, including specifically medical organizations, to provide for the training of members of the uniformed services at non-U.S. government facilities (see 10 U.S.C. 2013). Other provisions authorize the detail of members of the Army to “technical, professional, and other civilian educational institutions” to enable them “to acquire knowledge or experience in the specialties in which it is considered necessary that they perfect themselves” (see 10 U.S.C. 4301).

Related DoD policy and guidance have been promulgated for some of these activities, including GTAs for the Training with Industry program that provides “training and/or development of skills in private sector procedures and practices not available through existing military or advanced civilian education programs or other established training and education programs” (see Under Secretary of Defense for Personnel and Readiness, 2007); details of DoD personnel to help promote “increased effective . . . and more economic use of government resources” (see Director of Administration and Management, 2013); and the requirements for medical readiness training, including deployment-related training (see Assistant Secretary of Defense for Health Affairs, 2011).

Although applicable primarily to GME, pertinent Army regulations provide detailed policy guidance, criteria, and instructions for a wide variety of Army training programs, including general provisions for education and training in civilian institutions (see Headquarters, Department of the Army, 2007a), as well as more specifically for education and training of MEDCOM personnel (including both GME- and non-GME training in civilian institutions) (see Headquarters, Department of the Army, 2007b).

Interestingly, there is very specific recent guidance for post-deployment (“redeployment”) refresher training for physicians who are deployed for more than 60 days. Options for providing such training include “[o]ff-site training in affiliated civilian institutions if sufficient services are not available with the military healthcare system” (see Coley, 2012). We could not find similar specific guidance for pre-deployment training. Policy and guidance from OTSG/MEDCOM for non-GME training and other external activities with non-VA civilian facilities is both dated and not very comprehensive. That policy and guidance is contained in OTSG, 2000 (see Appendix C; OTSG, 2000). Its stated purpose is establishing “gratuitous agreements . . . with local teaching hospitals so that [MTF] staff physicians can participate in necessary skills augmentation, maintenance, or enhancement training.” Such training agreements appear to be the sole non-GME-related mechanism for military medical providers to provide care to civilian (non-MHS or VA beneficiary) patients—that is, only while undergoing training. The 2000 guidance provides templates for two relevant types of gratuitous agreements, including one specifically for medical residency training rotations (i.e., GME) and another for Training with Industry programs.

Liability Issues

Issues of potential liability for medical malpractice while providing medical services in a civilian facility have been topics of major discussion and policy guidance from the U.S. Department of Justice and military authorities. Although it appears that such issues have been largely resolved, the research team asked all stakeholders whether liability issues had posed any challenges or impediments in their agreements. Generally, Army medical professional personnel engaged in activities within the line and scope of their duties under approved agreements with civilian entities are protected under the general statutory provisions for federal tort claims (see 28 U.S.C. Chapter 171). The Federal Tort Claims Act (Pub. L. 79-601, Title IV) shields government employees generally from exposure to individual liability, and a com-

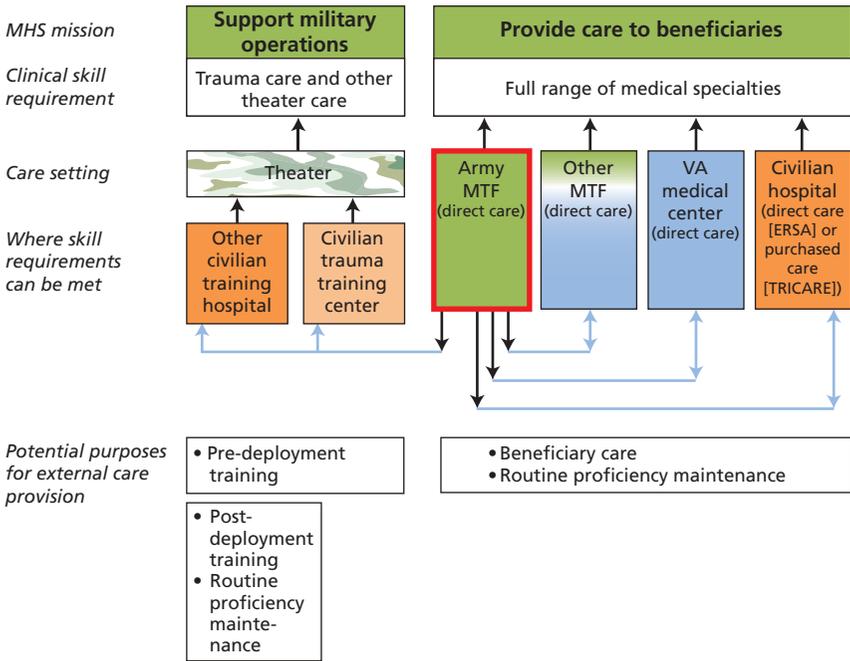
panion measure extends that liability protection specifically for DoD medical professional personnel (see 10 U.S.C. 1089). Depending on the type of activity and the specific terms of the agreement with the civilian entity, Army medical professional personnel can also be provided coverage under the civilian entity's liability insurance policies.

Information from the Medical Training Facility Data Call

As described in Chapter One, the RAND Arroyo Center project team sought information from various complementary sources to learn about the nature and circumstances in which Army medical personnel provide care in civilian or VA health facilities—whether to maintain or augment their skills or to provide care to MHS or VA beneficiaries. This chapter describes the key findings from the data call that OTSG directed for purposes of this study. Figure 3.1 depicts the potential purposes for such practice within the context of our conceptual framework; the various settings and reasons were a major focus of the MTF data call.

The MTF data call included responses from all 28 MTFs under Army management (100-percent response rate). Of these, 13 MTFs indicated that military medical personnel under their command provide care in VA or non-VA civilian facilities (Table 3.1). Two additional MTFs (Womack AMC at Fort Bragg and McDonald Army Health Center at Fort Eustis) reported that personnel provide care outside their assigned MTFs but still within MHS—only at an affiliated MTF or other DoD facility. Nine of the 13 remaining MTFs that reported no outside practice indicated that their routine and deployment-related medical readiness needs were met at the MTFs (MTFs at Fort Lee, Fort George G. Meade, Fort Benning, Fort Hood, Fort Irwin, Fort Huachuca, Fort Leavenworth, Fort Riley, and Redstone Arsenal); the four others did not specify a reason (MTFs at Fort Rucker, Fort Polk, and Fort Leonard Wood), although one (at Fort Jackson) indicated that it had sent personnel to a local VA in the past and was working on

Figure 3.1
Purposes and Settings for External Medical Practice



RAND RR1313-3.1

Table 3.1
Medical Treatment Facilities with Professionals Providing Care Outside the Assigned Medical Treatment Facilities, and Type of Outside Facility

MTF	At Civilian Facility?			At Another MHS Facility?	
	VA Facility	Non-VA Civilian Facility	Total	Affiliated MTF	Another DoD MTF
NRMC	1	3	3	4	2
Keller ACH, West Point	x	x	x	x	
Ireland ACH, Fort Knox		x	x	x	x
GAHC, Fort Drum		x	x		

Table 3.1—Continued

MTF	At Civilian Facility?			At Another MHS Facility?	
	VA Facility	Non-VA Civilian Facility	Total	Affiliated MTF	Another DoD MTF
Womack AMC, Fort Bragg				x	
McDonald Army Health Center, Fort Eustis ^a				x	x
Kenner Army Health Clinic, Fort Lee ^a					
Kimbrough Ambulatory Care Center, Fort George G. Meade ^a					
PRMC	0	1	1	0	0
TAMC, Fort Shafter ^a		x	x		
SRMC	3	3	5	2	3
Winn ACH, Fort Stewart		x	x	x	x
Reynolds ACH, Fort Sill		x	x		
DDEAMC, Fort Gordon	x	x	x		x
SAMMC, JBSA–Fort Sam Houston ^a	x		x	x	x
Blanchfield ACH, Fort Campbell	x		x		
Moncrief ACH, Fort Jackson					
Martin ACH, Fort Benning					
Lyster Army Health Clinic, Fort Rucker					
Fox Army Health Center, Redstone Arsenal					
Carl R. Darnall AMC, Fort Hood ^a					
Bayne-Jones ACH, Fort Polk					

Table 3.1—Continued

MTF	At Civilian Facility?			At Another MHS Facility?	
	VA Facility	Non-VA Civilian Facility	Total	Affiliated MTF	Another DoD MTF
WRMC	1	4	4	0	1
WBAMC, Fort Bliss	x	x	x		
Madigan AMC, JBLM ^a		x	x		
Evans ACH, Fort Carson ^a		x	x		x
Bassett ACH, Fort Wainwright		x	x		
Weed ACH, Fort Irwin					
Raymond W. Bliss Army Health Center, Fort Huachuca					
Munson Army Health Center, Fort Leavenworth					
Irwin ACH, Fort Riley					
General Leonard Wood ACH, Fort Leonard Wood					
Total (<i>n</i> = 28)	5	11	13	6	6

NOTE: PRMC = Pacific RMC. TAMC = Tripler Army Medical Center. SAMMC = San Antonio Military Medical Center. JBSA = Joint Base San Antonio. AMC = Army medical center. JBLM = Joint Base Lewis-McChord.

^a MTF in a local eMSM.

a new agreement to do so again. Eight of the 28 Army-managed MTFs are part of a local enhanced MSM (eMSM); of these, three reported on personnel providing care at VA or non-VA civilian facilities, and five did not. At the time of the MTF data call, discussion with OTSG staff and review of documents and published papers had indicated that training for medical readiness needs was likely to be the major reason for outside practice; there was little indication at that time that external practice to provide beneficiary care was as prevalent as it was. Therefore, the data request did not specifically solicit explicit information

about the MTFs' perceived needs for ERSAs or VA resource-sharing agreements, nor did it ask specifically about the need for outside practice from the MTFs that are part of eMSMs.

Perhaps surprisingly, larger facilities were more likely to have practitioners who provide care in VA or non-VA civilian facilities: Five of seven AMCs (71 percent), seven of 13 ACHs (54 percent), and just one of eight Army health clinics or centers (13 percent). Although these numbers are small, none of our sources of information pointed to reasons for these differences.

There is reason to believe that MTFs' reporting is incomplete. For example, at one of the four sites visited, we received four additional agreements that the MTF had not previously reported—two VA–DoD sharing agreements and two GTAs. Also, subsequent comparison of ERSAs that the MTFs in one region reported and a list of ERSAs that the region's TRICARE management support contractor provided indicated that the MTFs reported five ERSAs in place at the time of the data call (in July 2014) but not seven additional ERSAs. Finally, MTFs reported very few GTAs. Although the intent of the data call was to include them, it is conceivable that MTFs misinterpreted the request and not reported them. However, such underreporting might be minimal because nine of 13 MTFs not reporting external practice specifically indicated that their routine and pre-deployment medical readiness needs were met at the MTFs, suggesting that GTAs for such training were not needed. Most of the descriptions that follow refer to information that the 13 MTFs that reported outside practice in at least one VA or non-VA civilian facility provided through the data call.

As shown in Table 3.1, most outside care is provided at non-VA civilian facilities: Professionals from eight of 13 MTFs provide care only at non-VA facilities; three of 13 at both VA and non-VA facilities, and two at VA facilities only. Each of the 13 MTFs had personnel practicing in one to six civilian or VA facilities, in a total of 33 such facilities. All outside practice is through formal agreement. We found many of those agreements in the central MEDCOM repository of agreements (see Chapter Four). Six of them involve exchange of funds, including four in which DoD provides funding to the civilian or VA facility and two in which the facility pays DoD. For all 13 MTFs whose personnel

provide care in VA or other civilian facilities, the Army covers malpractice liability.

The most frequent reasons cited for providing care outside the home MTFs are to serve beneficiaries (ten out of 13); meet routine proficiency maintenance needs (eight out of 13); and meet pre-deployment needs (two out of 13). No MTF reported external practice to meet post-deployment needs (Table 3.2). Some MTFs offered further justifications for providing care at civilian or VA facilities (Appendix D, Table D.1): Service is not provided at the MTF (eight of 13); service is provided at the MTF, but patient volume or mix is insufficient (three of 13, including the one military medical center); service is provided, but there are insufficient auxiliary personnel at the MTF (two of 13); or external practice serves as an incentive for retention of Army medical talent (four of 13).

Most military medical personnel currently providing care in VA or other civilian facilities are physicians; among them, most are surgeons, including general, orthopedic, thoracic, urology, plastic, obstetrics and gynecology, otolaryngology, ophthalmology, and podiatry (see details in Appendix D, Tables D.2 and D.3). Only two of the 13 MTFs also have non-surgical specialties (family medicine, internal medicine, neurology, or psychiatry) engaged in external practice.

Finally, most MTFs (nine of 13) reported that they deploy *individuals only* to provide care in VA or other civilian facilities; one deploys a *team only*, and three deploy *both individuals and teams* (Appendix D, Table D.4).

Table 3.2
Reasons for Care at Department of Veterans Affairs or Other Civilian Facility

MTF	Meet Routine Proficiency Needs	Meet Pre-Deployment Proficiency Needs	Meet Post-Deployment Proficiency or Reintegration Needs	Serve Local Military Beneficiaries	Other
NRMC	0	0	0	3	2
Keller ACH, West Point				x	x
Ireland ACH, Fort Knox				x	x
GAHC, Fort Drum				x	
PRMC	1	0	0	1	0
TAMC, Fort Shafter	x			x	
SRMC	3	2	0	4	1
Winn ACH, Fort Stewart				x	
Reynolds ACH, Fort Sill				x	
DDEAMC, Fort Gordon	x			x	x
SAMMC, JBSA–Fort Sam Houston	x	x			
Blanchfield ACH, Fort Campbell	x	x		x	

Table 3.2—Continued

MTF	Meet Routine Proficiency Needs	Meet Pre-Deployment Proficiency Needs	Meet Post-Deployment Proficiency or Reintegration Needs	Serve Local Military Beneficiaries	Other
WRMC	4	0	0	2	0
WBAMC, Fort Bliss	x				
Madigan AMC, JBLM	x			x	
Evans ACH, Fort Carson	x				
Bassett ACH, Fort Wainwright	x			x	
Total (<i>n</i> = 13)	8	2	0	10	3

NOTE: When we conducted the study, the facilities were organized by RMC; reorganization into RHCs took place after we completed the study.

Types of Agreement and Review of Selected Agreements

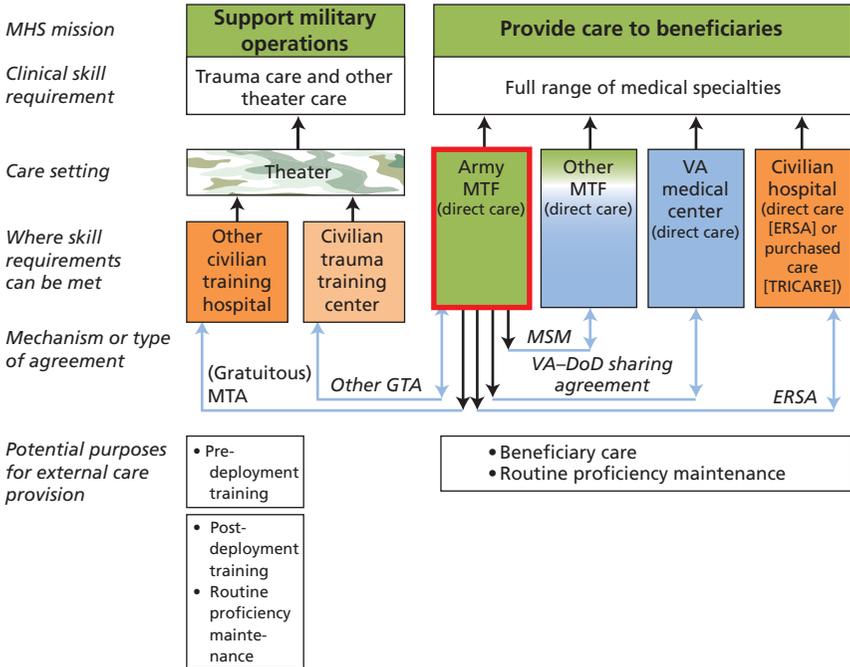
The second information source for this study relates to the different types of external medical practice and the associated agreements. This chapter describes the different mechanisms for external medical care resource sharing and training and then summarizes our review of relevant available agreements.

Mechanisms for External Medical Care Resource Sharing and Training

Because of conflicting pressures to reduce cost and cost growth of military medical care while improving services, as of FY 2014, the Defense Health Program sought to balance four management goals of medical readiness, a healthy beneficiary population, beneficiary satisfaction with health plan, and medical cost per beneficiary per year (see “Defense Health Program Fiscal Year [FY] 2014 Budget Estimates Appropriation Highlights,” 2013). To address costs, DoD officials implemented various strategies to standardize care across all DoD MTFs, allocating resources based on the value of care to the military mission, consolidating shared services, recapturing beneficiary patients within MTFs, and utilizing military–civilian agreements as appropriate. Thus, sharing medical care resources takes place through various mechanisms. Other types of agreement cover medical training. Figure 4.1 depicts this range of agreements, and Table 4.1 summarizes it.

Although the focus of the present study is Army medical practice in VA and non-VA civilian facilities, we also briefly describe a rel-

Figure 4.1
Purposes, Mechanisms, and Settings for Personnel Agreements with External Facilities



RAND RR1313-4.1

atively new model for sharing of medical care resources across military services: In eMSMs, delivery of health care is coordinated across multiple military services operating in a geographic area. Additional sharing mechanisms—external to DoD—that are the main focus of our analyses include VA–DoD resource-sharing agreements; provision of care to beneficiaries in non-VA civilian facilities through ERSAs; and augmentation or maintenance of skills, including care for civilian patients through GTAs, often labeled MTAs. TAAs (not shown in Figure 4.1) with educational institutions work in the opposite direction from GTAs and MTAs: They enable clinical assignment for health care students from a civilian institution to an MTF. Through these various mechanisms, each of which is discussed in more detail below,

Table 4.1
Mechanisms for Medical Care Resource Sharing and Training

Mechanism	Type of Facility and Direction of Placement ^a	Type of Patients	Authority or Policy
eMSM	Army MTF ⇔ Navy or Air Force MTF	MHS beneficiaries	Carter, 2013
VA–DoD resource-sharing agreement	Army MTF ⇔ VA medical center	MHS and VA beneficiaries	38 U.S.C. 8111; 10 U.S.C. 1104; Under Secretary of Defense for Personnel and Readiness, 2013b; Fiore, 2015
ERSA	Army MTF ⇔ TRICARE (managed care support contract) network civilian facility	MHS beneficiaries	10 U.S.C. 1096; 32 C.F.R. 199.17(a)(2), (h)(3), and (m)(4); TRICARE, 2008, Chapter 15
GTA (MTA, Training with Industry)	MTA: Military GME, residents, and fellows, short or long term ⇔ civilian educational institution MTA: Skill augmentation or post-deployment: Army MTF providers ⇔ local civilian hospital Military personnel detail ⇔ training in civilian sector or industry	Civilians and MHS beneficiaries	10 U.S.C. 2013; 10 U.S.C. 4301; Assistant Secretary of Defense for Health Affairs, 2011; Under Secretary of Defense for Personnel and Readiness, 2007; Headquarters, Department of the Army, 2007b; OTSG, 2000
MOA	Army MTF ⇔ civilian facility	MHS beneficiaries or civilians, depending on type of agreement	No specific statutory or DoD authority for MOA
TAA	Civilian students ⇔ Army MTF	MHS beneficiaries	Headquarters, Department of the Army, 2007b, Chapters 15 and 16

^a The directionality starts with the type of facility that is the provider’s home base, and the arrow points to the type of external facility (outside home base) where the provider provides care. An arrow going in both directions means that each side both sends and receives providers.

MHS aims to optimize its ability to enhance medical training, sustain degradable provider skills, and deliver care to its beneficiaries.

Enhanced Multiservice Markets

The MSM approach was designed to address costs by standardizing care across all DoD MTFs, allocating resources based on the value of care to the military mission, consolidating shared services, recapturing beneficiary patients within MTFs, and utilizing military–civilian agreements as appropriate. A relatively new version of this model is the eMSM approach, in which delivery of health care is coordinated across multiple military services operating in a geographic area. The Deputy Secretary of Defense established the eMSM system as part of the implementation of MHS governance reform (see Carter, 2013). The eMSMs enable the DHA to manage and oversee execution of medical care resources and services across the military services, including the adoption of common clinical and business functions. The eMSM model was not within the original scope of this study, but we include mention of it because it will be another important approach to Army medical care resource sharing, albeit under the DHA rather than Army management.

Currently, six eMSMs are designated across MHS—Colorado Springs, Colorado; National Capital Region; Oahu, Hawaii; Puget Sound, Washington; San Antonio, Texas; and Tidewater, Virginia (see DHA and MHS, undated [b]). These MSMs represent 35 percent of the total direct-care cost of MHS. Each eMSM is jointly affiliated with more than one military service, must have a catchment population of at least 65,000 beneficiaries, and must have a high patient workload (see Robb, 2013). As noted in Table 3.1 in Chapter Three, eight of the 28 MTFs currently under MEDCOM management are part of eMSMs. Authorities at eMSM are responsible for (see DHA and MHS, undated [b])

- managing the allocation of the budget for the market
- directing the adoption of common clinical and business functions for the market

- optimizing readiness to deploy medically ready forces and ready medical forces
- directing the movement of workload and workforce between or among MTFs
- improving the integration and continuity of direct- and purchased-care entities within the market.

Department of Veterans Affairs–Department of Defense Health Care Resource-Sharing Agreements

Both DoD and VA have medical care facilities throughout the country, and they are clearly linked by virtue of their respective beneficiary populations. In recent years, policy and practice have brought DoD MTFs and VA medical centers together to share resources in both directions, for the mutual benefit of both. The statutory authorities and DoD and Army OTSG/MEDCOM guidance for such arrangements are described above (and summarized in Table 4.1). Each local VA–DoD sharing agreement takes into account VA’s needs, DoD’s capabilities (e.g., available capacity), and the local medical market. Through such agreements, Army medical professionals (mostly physicians) can help reduce VA patient backlog while also maintaining or enhancing their technical proficiency. However, there can be challenges when two established organizations try to share resources. A 2012 GAO report (GAO, 2012b, cover) that addressed some issues between VA and DoD concluded, among other things, the following:

The departments [VA and DoD] face a number of key barriers that hinder collaboration efforts. In particular, GAO identified incompatible policies and practices in [several] areas:

- Information technology (IT) systems. Because VA and DOD collect, store, and process health information in different IT systems, providing access to information needed to best treat patients has proved problematic.
- Business and administrative processes. Different billing practices, difficulties capturing patient workload information, and overlapping efforts in credentialing providers and computer security training reduce efficiency.

External Resource-Sharing Agreements

ERSAs with non-VA civilian health care facilities “enable military health care personnel, active duty and civilian, to provide covered medical services to active duty and TRICARE beneficiaries in a network facility” (10 U.S.C. 1096; also see TRICARE, 2008, Section 2.0, Chapter 15). Under an ERSA, a military provider cannot see a beneficiary who is also covered by Medicare unless for a service that Medicare does not cover (32 C.F.R. 199.17[h][3]; TRICARE, 2008).

ERSAs are tools that MTF commanders use to enable military providers to provide covered medical care to eligible beneficiaries in participating network facilities where sufficient military facilities or equipment are not readily available. Such a situation can be the result of a temporary or permanent reduction of operating rooms, clinical space, a reduction of clinical support staff, or delays in acquiring needed medical equipment. Agreements using military health care providers within civilian facilities are in lieu of care that would be provided solely by civilian medical personnel in such facilities. ERSAs are also used to maintain clinical currency for procedures not available at MTFs and to avoid costs of medical professional service fees (see DHA and MHS, undated [a]). (Note that the civilian facility cannot bill the military provider fee except to a third-party insurer for *non-active duty*.)

These ERSAs are written agreements between the TRICARE contractor, MTF commander, and network facility, with the concurrence of the RMC. The MTF commander must ensure that the provider has active clinical privileges with the network facility and is licensed to practice medicine in a U.S. jurisdiction.¹ As we learned in our site visits and interviews, military providers operating under ERSAs must go through credentialing procedures at the network facilities, and those procedures often vary from one facility to another—even in the same community. The guidance also specifies that the ERSAs “shall set forth all the terms, conditions and limitations of the resource sharing arrangements,” but it does not provide a full ERSA template; it provides mandatory text for only one element of such agreements—a required

¹ In some cases, civilian facilities might also require military providers to be licensed in the state where the facility is located.

professional liability clause (see TRICARE, 2008, Sections 4.0 and 5.0).

We could not find more-specific guidance for ERSAs that is consistent with the recent comprehensive policy memo for VA resource sharing, noted above.

Gratuitous Training Agreements

MTAs are one type of GTA. They enable training of military personnel in civilian facilities. These agreements include GME-related training for military physicians, from medical school through residency and fellowship, both short and long term, as well as skill augmentation or post-deployment training for MTF providers in a local accredited teaching hospital. The purpose of military–civilian partnerships expanded in March 2000, with the release of an Army Surgeon General memo that discussed the utility of GTAs. This guidance authorized commanders of the RMCs to designate certain clinical skills as mission-essential and to “enter into gratuitous agreements with local teaching hospitals (with appropriate legal review) so that staff physicians can participate in necessary mission essential skills augmentation, maintenance, or enhancement training” (see OTSG, 2000, also reproduced in Appendix C). An institution from which an MTF provider receives such training must be affiliated with an accredited training program.

Other agreements covered by this memorandum are GTAs with industry under the Training with Industry program. The program “is designed to provide training and/or skills in industrial procedures and practices not available through existing military or advanced civilian schooling programs” (see Headquarters, Department of the Army, 2007b). The March 2000 memo provided an example of such an agreement for an Army physician. These agreements do not require that the civilian institution be affiliated with an accredited training program. In practice, however, MEDCOM officials indicated that they rarely use such agreements, opting instead to use MTAs and ask for legal exceptions to the training institution requirement for the civilian facility.

One important set of GTAs is for trauma training. Skilled medical trauma teams are essential for providing effective combat care to the warfighter. Following a 1996 report to Congress on military trauma

training in civilian facilities, the military services undertook seven new partnership agreements (see Thorson et al., 2012).

These trauma training military–civilian partnerships provide another mechanism for military personnel to augment or maintain proficiency for combat care. They differ substantially from early military–civilian partnership programs in that they tend to be short and systematic, with an emphasis on training rather than cost. DoDI 1322.24 provides authority for the services to implement skill training for military medical personnel deploying on military operations (Assistant Secretary of Defense for Health Affairs, 2011). DoDI 1322.24 differentiates between initial and sustainment readiness training, with the former preparing a unit to deploy and the latter describing general skills deployable physicians should have.

One trauma center in Florida is an example of a trauma training center as depicted in Figure 4.1. The Army sends forward surgical teams (FSTs) to this trauma center for a two-week training prior to deployment (Schulman et al., 2010). At the end of the training, the entire 20-person FST runs the entire trauma center together for 48 hours (Thorson et al., 2012). By 2012, approximately 2,300 Army personnel (95 FSTs) had rotated through the program (Thorson et al., 2012). The program operates with ten military instructors who rotate through the program every two years. The Navy’s trauma training program consists of classes of approximately 30 personnel who train together for 30 days at time (Thorson et al., 2012).

Memoranda of Agreement

MOAs outline specific terms of responsibilities and commitments of either resources or actions by at least one party. They encompass some of the agreements described above. They can originate locally, regionally, or from OTSG or MEDCOM and can be used to enhance the clinical skills of military health care providers. Examples include short-term MTAs for military residents or fellows under Army Regulation 351-3 (see Headquarters, Department of the Army, 2007b); skill-enhancement MTAs for staff physicians to teaching hospitals under the OTSG 2000 memo (see OTSG, 2000, also reproduced in Appendix C); and skill-enhancement MTAs on an exception basis for mili-

tary non-physician health care providers for destinations other than teaching hospitals. Military health care providers also use MOAs to provide care to eligible beneficiaries at non-military medical facilities (i.e., ERSAs).

Training Affiliation Agreements

TAAAs work in the opposite direction from those described above: They provide for health care students from a civilian institution to have clinical assignments at MTFs. Although such agreements are, by the nature of this study, outside the scope of our consideration, we make note of them here for the sake of completeness and because they were mentioned during two of our four site visits. The TAA mechanism is not included in Figure 4.1.

Review of Selected Agreements

The project team reviewed 30 agreements: 19 ERSAs, two DoD–VA sharing agreements, eight GTAs, and one MOA (Table 4.2). The 30 agreements included 26 from the central MEDCOM repository and four not reported by one MTF but provided during the team’s visit to that site. Through the data call, MTFs reported 30 agreements, including 15 that were in the MEDCOM repository and 15 that were not (and thus were not available for review because the data call had not requested transmission of agreements).

Nearly all MTFs that reported external medical practice use ERSAs (12 out of 13); far fewer use VA–DoD sharing agreements (four out of 13), GTAs (two out of 13), or MOAs (one of 13). Table 4.3 is a more detailed summary of these agreements, by military installation, type of agreement, and source of identification (project team identification from the MEDCOM repository or reported or provided by the MTFs). The sections that follow describe and analyze each type of agreement; following these sections is a comparison of the characteristics of the agreements examined.

Table 4.2
Different Types of Agreement Identified and Available for Review

Type of Agreement	Number Available from Repository or Site Visit	Number Reported by MTF but Not Available from Repository or Site Visit	Total Number
ERSA	19	11	30
VA–DoD	2	4	6
GTA	8	0	8
MOA	1	0	1
Total	30	15	45

Table 4.3
List of Agreements Examined

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
NRMC (eight agreements)	6	7	
Keller ACH, West Point	x	x	ERSA with center A for ambulatory orthopedic surgery services during periods that the MTF operating room is closed or otherwise not available ^a
	x		ERSA with hospital A for inpatient obstetric services provided by active-duty physicians (obstetricians) and inpatient and outpatient surgical services by active-duty surgeons during periods when the MTF operating room is closed or otherwise not available ^a
Ireland ACH, Fort Knox		x	DoD/VA sharing agreement with VA medical center A
		x	ERSA with hospital B

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
GAHC, Fort Drum	x	x	ERSA with hospital C for medical, surgical, and obstetric services to inpatient, ambulatory, and observation care patients; providers can include physicians, nurse practitioners, physician assistants, midwives, and other non-physician providers, such as podiatrists, in specialty areas of obstetrics, gynecology, orthopedics, podiatry, family practice, and pediatrics ^a
	x	x	ERSA with hospital D inpatient and outpatient orthopedic surgery services provided by orthopedic surgeons and non-physician providers, such as surgical assistants (pre- and postoperative care to be provided at the MTF) ^a
	x	x	ERSA with hospital E for inpatient and outpatient medical and surgical services provided by physicians, physician assistants, and other non-physician providers, such as podiatrists ^a
	x	x	ERSA with hospital F for inpatient and outpatient medical and surgical services provided by physicians, physician assistants, and other non-physician providers, such as podiatrists ^a
PRMC (four agreements)	1	3	
TAMC, Fort Shafter	x		MOA with community clinic A for TAMC personnel to provide telebehavioral health services ^a
		x	ERSA with medical center A
		x	ERSA with hospital G
		x	ERSA with surgical center A

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
SRMC (13 agreements)	7	8	
Winn ACH, Fort Stewart		x	ERSA with medical center B
Reynolds ACH, Fort Sill		x	ERSA with medical center C for orthopedic surgery, otolaryngology, and general surgery
DDEAMC, Fort Gordon	x		ERSA with center B to provide obstetric services ^a
	x		ERSA with center B to provide pediatric surgical, pediatric gastroenterology, and high-risk obstetric delivery services ^a
	x	x	ERSA with hospital H for obstetric, family practice, and pediatric services ^a
		x	VA–DoD resource-sharing agreement with VA medical center B
		x	VA–DoD resource-sharing agreement with VA medical center C

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
SAMMC, JBSA—Fort Sam Houston	x	x	VA—DoD resource-sharing agreement with VA hospital A surgery services provided to VA patients at the MTF, including general surgery, otolaryngology, gynecology, urology, orthopedic, vascular surgery, and neurosurgery ^a
	x		GTA with center C for a single named physician (an ophthalmologist) to provide diabetic eye-disease care ^a
	x		GTA with center D for a single named physician (a urologist) to provide reconstructive and prosthetic genitourinary surgery ^a
	x		GTA with center C for a single named physician (a pediatric cardiologist) ^a
Blanchfield ACH, Fort Campbell		x	VA—DoD resource-sharing agreement with VA center E
		x	ERSA with medical center D
WRMC (16 agreements)	8	16	

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
WBAMC, Fort Bliss	x	x	ERSA with medical center E for obstetrics, gynecology, and urology services ^a
	x	x	ERSA with hospital I for surgical inpatient and medical inpatient and outpatient care ^a
	x	x	ERSA with medical center F for surgical inpatient and medical inpatient and outpatient services ^a
		x	ERSA with medical center G for outpatient surgical services ^a
		x	ERSA with specialty center A for orthopedic surgical services ^a
		x	VA–DoD resource-sharing agreement with the VA health care system
		x	GTA with hospital J for a practical nursing program ^a
		x	GTA with hospital K for a practical nursing program ^a
	Madigan AMC, JBLM		x
		x	ERSA (assumed) with center D for obstetrics and gynecology

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
Evans ACH, Fort Carson	x	x	ERSA with hospital M for orthopedic, otolaryngology, urology, and general surgery services ^a
	x	x	ERSA with hospital N for inpatient, outpatient, and surgical services ^a
	x	x	ERSA with hospital O for inpatient, outpatient, and surgical services ^a
	x	x	ERSA with center E for psychiatric stabilization and detoxification ^a
	x	x	ERSA with hospital P for psychiatric stabilization and detoxification ^a
Bassett ACH, Fort Wainwright		x	ERSA with hospital Q for internal and family medicine, family nurse practitioner, psychiatry, general and orthopedic surgery, and otolaryngology

Table 4.3—Continued

MTF	Number of Agreements		Description of Agreement
	In MEDCOM Repository	Reported or Provided by MTF	
Other (OTSG or MEDCOM) (four agreements)	x	Not applicable	GTA with trauma center A to provide full-time physicians to oversee training of Army FSTs (expired) ^a
	x	Not applicable	GTA with hospital R for two full-time general surgeons to oversee training of Army FSTs and to provide FST trainees on a rotational basis (expired) ^a
	x	Not applicable	GTA with trauma center B to provide full-time military staff in eight specified occupational categories to oversee training of Army FSTs and to provide FST trainees on a rotational basis (expired) ^a
	x	Not applicable	VA–DoD resource-sharing agreement for the Army to provide one (unnamed) board-certified or eligible cardiothoracic surgeon to provide full-time care in a VA facility (expired) ^a
Total (45 agreements, of which 30 are available for examination)	26	34	

NOTE: When we conducted the study, the facilities were organized by RMC; reorganization into RHCs took place after we completed the study.

^a Agreements available and examined.

External Resource-Sharing Agreements

As is inherent to the intent of ERSAs, all 19 ERSAs examined were initiated to enable military providers to care for beneficiaries at local civilian facilities. Military providers authorized under the government contract agreement signed by the MTF commander, third-party insurer, and civilian medical facility provided both inpatient surgical and medical services and outpatient care. Each ERSA specifically prohibits the

exchange of reimbursable fees to the MTF and states that military providers would have malpractice and liability coverage when working in the civilian facility as part of their military jobs. Most ERSAs were non-specific in nature and did not mention the type of specialty of the military medical provider. Only six of the 19 (32 percent) specified the physician specialty (AOCs given in parentheses): orthopedics (61M); obstetrics and gynecology (60J); family practice (61H); pediatrics (60P); ear, nose, and throat (ENT) (60T); urology (60K); or gastroenterology (60G). Six of 19 (32 percent) specified non-physician personnel who include physician assistant (65D) or podiatrist (67G), and one ERSA specified nurse practitioners (66P) and midwives (66W).

ERSAs from a given MTF look virtually identical to one another but different from ERSAs developed by other MTFs. Although none of the ten ERSAs from two MTFs (at Fort Carson and Fort Bliss) mentions anything about cost to TRICARE, all nine ERSAs from three MTFs (at Fort Drum, Fort Gordon, and West Point) include explicit language in the agreement about cost avoidance to TRICARE (for example, “to contain TRICARE costs, for both the federal government and the beneficiaries” and “thereby reducing total costs through an arrangement with the Facility . . . in lieu of care that would otherwise be provided outside of the MTF, at higher cost, by [TRICARE providers]”).

Department of Veterans Affairs–Department of Defense Resource-Sharing Agreements

The two VA–DoD resource-sharing agreements that we examined are mutually beneficial to both DoD and VA, sharing, using, and exchanging health care resources, including space or personnel. As we also learned from interviews and site visits, the overall goal of all of these sharing agreements is to improve access to and quality, efficiency, and effectiveness of the health care that MHS and the Veterans Health Administration provide to their respective beneficiaries.

The team reviewed two such agreements, both of which were complete and thorough. One agreement was between SAMMC providers and South Texas Veterans Health Care System to provide surgical service support for VA beneficiaries, including general surgery, vascular,

otolaryngology, cardiothoracic surgery, plastics, neurosurgery, ophthalmology, gynecology, and orthopedic surgery. The other one, originating from MEDCOM, describes using a military board-certified or eligible active-duty cardiothoracic surgeon to provide full-time care in a VA facility for a period of three years at an annual cost savings to VA of approximately \$100,625 for the physician's services. The agreement does not specify either the physician or the VA medical center.

Gratuitous Training Agreements

MTAs are the most commonly known and used type of GTA. They allow for individual medical personnel to provide clinical care to augment, maintain, and enhance skills at a civilian facility because the MTF does not have the volume and mix of cases to provide the necessary training. In many instances, such GTAs or MTAs are for by-name specific providers who will treat patients at civilian medical facilities. They allow the military medical professional to care for civilian patients within the context of training. The eight agreements we reviewed did not indicate whether a provider would see military beneficiaries only, civilians only, or a combination of both. Because health care needs can change per MTF and the emphasis of types of training can also change, GTAs and MTAs can become inactive. When this occurs, the agreements are usually not terminated upon completion of the specified training. These training agreements can remain in place and be reactivated when necessary. Of the four sites we visited, only one site used GTAs (two such agreements) for training students in the Nurse Practical course.

Three of the GTAs reviewed were between SAMMC and center C. Each agreement specifies that skill sustainment and enhancement are the primary reason for entering into the agreement. The skills identified in each agreement are as follows:

1. The ophthalmologist (60S) agreement specifies that “interaction with advanced diabetic eye disease patients is not currently available in normal duties at BAMC [Brooke Army Medical Center].”

2. The urologist (60K) agreement specifies that “the required number of cases is currently not available through normal duties at BAMC such as traumatic reconstructive and prosthetic [genitourinary] surgery.”
3. The pediatric cardiologist (60Q) agreement specifies “interaction with pediatric patients and pediatric cardiology inpatient procedures . . . not currently available in normal duties at BAMC.”

As indicated by their name, GTAs involve no exchanges of funds from the MTF to the university; however, the university agrees to provide malpractice coverage to military providers.

The three final GTAs originated from MEDCOM and deal with training of FSTs at different civilian hospitals that provide trauma training to enhance and sustain “go-to-war” trauma skills (training to enhance and sustain trauma skills needed in a combat setting). These GTAs specify the number of providers in each FST training group as either one or two general surgeons (61J); one orthopedic surgeon (61M); two nurse anesthetists (66F); one critical care nurse (66H); one operating room nurse (66E); one emergency room nurse (66H); and auxiliary staff (licensed vocational nurse, operating room technicians, emergency medical technicians, and health service administrators). Military medical personnel assigned to the civilian hospital conduct and oversee FST training. FST training rotations usually consist of 20 to 24 medical personnel reporting for training for two-week training periods.

Memoranda of Agreement

The one MOA reported and available for review highlights the agreement between TAMC in Honolulu, Hawaii, and remote sites at the Community Clinic of Maui for TAMC personnel to provide behavioral tele-health services to military beneficiaries. Patients are considered TAMC patients and not patients of the Community Clinic of Maui. The services are outpatient cases only, and the MOA does not specify the skill level of the provider (i.e., physician or non-physician); however, the provider does have malpractice and liability coverage that

the Army provides. Additionally, the services that the MOA covers are contingent on continued funding for TAMC behavioral tele-health programs.

Comparison of Agreement Characteristics

The project team examined the content of the 30 agreements described above, and Table 4.4 shows the results. We could not find any standard templates for completing ERSAs, and the information contained in the 19 ERSAs reviewed was not uniform. For example, only 32 percent (six out of 19) of ERSAs provided information on the type and specialty of provider that the agreement requires, and no agreement specified the number of providers covered under the agreement. Both the 19 ERSAs and the one MOA specified inpatient or outpatient services, while the eight GTAs did not. Each agreement had a clear statement on legal or DoD authorities, responsibility of parties, term of agreement, and funding. The two VA–DoD resource-sharing agreements were the most standardized and complete of all the agreements; however, the information contained in the GTAs was also very complete and standardized with the addition of specified courses, course location, and reporting authority pertinent to the nurse practical course.

In summary, the legal aspects of these agreements are very thorough. Clearly written legal statements pertaining to DoD authorization, delineation of interested parties' responsibilities, funding, and legal basis of liability coverage are well covered and apparent. However, the specification of types and number of providers covered in the various types of agreements is not consistent across the different types of agreements. During the four site visits, interviewees reported preferring generic agreements that cover a broad spectrum of opportunities and provider types rather than agreements that specify providers by name or specialty, which could become outdated more quickly than generic statements. Finally, we found that most—albeit not all—agreements that the MTFs reported were in the central MEDCOM repository. However, one of the MTFs visited provided four additional agreements that were reported neither through the data call nor in the MEDCOM repository. Therefore, there appears to be no single place where all such agreements can be found.

Table 4.4
Comparison of Medical Treatment Facility Agreement Characteristics:
Percentage of Agreements with Each Characteristic

Agreement Characteristic	ERSAs (19)	VA–DoD Resource- Sharing Agreements (2)	GTAs (8)	MOAs (1)
Clear statement of legal or DoD authorities	100	100	100	100
Clear statement of parties to agreement	100	100	100	100
Clear statement of each party's responsibilities	100	100	100	100
Term of agreement specified	100	100	100	100
Type of provider specified (e.g., physician, nurse)	32	100	100	100
Specialty of provider specified	32	100	100	0
Number of providers specified	0	100	75	0
Inpatient or outpatient service specified	100	100	0	100
Statement or section regarding funding	100	100	100	100
Statement on liability coverage responsibilities	100	100	100	0

NOTE: The legal basis for DoD liability coverage for ERSAs, VA–DoD resource-sharing agreements, and GTAs is the Federal Tort Claims Act as codified at 28 U.S.C. 1346(b) and 2671–2680. The basis for MOAs is not specified.

Findings from Stakeholder Discussions, Including Site Visits

This chapter describes the series of interviews that we conducted with subject-matter experts in the Army, Navy, Air Force, and OSD to better understand the context in which agreements are created and implemented; determine what authorities are relevant, existing, or needed; describe how the agreements are executed; and determine the benefits and challenges of continuing the agreement process. Chapter One describes the general interview protocol and sampling method, and Appendix A lists offices interviewed.

Also as described in Chapter One, the project team used several criteria to identify an appropriate mix of sites for more in-depth consultation. Our goal was to reflect a range of locations, center types, types of outside facilities, reasons for outside practice, professional types and specialties, and individual and team practice in such facilities. We also sought a mix of MTFs for which there were and were not agreements found in the MEDCOM repository. After selecting sites using these criteria, the team visited four different sites. In this chapter, we describe each site and the key findings from all of the stakeholder discussions, including those at the four sites visited.

Sites Visited

Dwight D. Eisenhower Army Medical Center, Fort Gordon, Georgia

DDEAMC is a 300-bed hospital located in Augusta, Georgia, and under the SRMC. It provides primary care and most medical and surgical specialty care and is affiliated with five smaller MTFs (labeled “child”

MTFs, which are under the parent MTF's command): two in Georgia and one each in Florida, Mississippi, and Puerto Rico. DDEAMC's 40-mile-radius catchment area includes an eligible beneficiary population of 48,882, of whom 37,247 are enrolled. The closest trauma center is the Georgia Health Sciences University, 12 miles away. Through the data call, DDEAMC reported that, of 111 assigned clinical full-time-equivalent physicians, 11 provided care away from their assigned MTFs, in VA or civilian facilities, to maintain proficiency or provide services to military beneficiaries. These physicians are three thoracic surgeons, one plastic surgeon, one neurologist, two obstetrician/gynecologists, and four family medicine specialists. DDEAMC has long-standing agreements with two VA medical centers, one in Augusta and the other in Dublin (Georgia), and more-recent agreements with the VA medical center in Columbia, South Carolina, and with four civilian TRICARE network facilities, all located in Augusta. Most of these agreements relate to GME. Three agreements relevant to this study were in the MEDCOM central repository.

Guthrie Ambulatory Health Care Clinic, Fort Drum, New York

GAHC is an ambulatory care clinic located in northeastern upstate New York and under the NRMC. The local eligible beneficiary population is 34,092, of whom 31,347 are enrolled. GAHC provides relatively few specialized medical services (audiology, chiropractic, clinical psychology, dermatology, family medicine, optometry, pediatrics, podiatry, psychiatry, and substance abuse) and even fewer services related to surgical specialties (pre-operative and post-operative follow-up care for obstetrics, gynecology, and orthopedics but not the surgical procedures themselves). The closest trauma center is 81 miles away, in Syracuse. GAHC has four small child MTFs and is affiliated with four nearby civilian facilities. These civilian facilities provide several services not available at GAHC, such as cardiology (three hospitals), dental (one hospital), emergency services (two), internal medicine (two), laboratory (one), mental health (one), primary care (one), radiology (three), and surgery (three). Therefore, active-duty and other beneficiaries receive much of their medical care at these facilities because services are not available at the local MTF (GAHC). Through the data call,

GAHC reported that all five medical professionals (two obstetrician/gynecologists and one orthopedic surgeon, one obstetric/gynecological nurse, and one physician assistant), working in teams, provide obstetric, gynecological, and orthopedic surgery services to beneficiaries at these hospitals. Relevant agreements with all four of the civilian facilities were in the central MEDCOM repository.

Evans Army Community Hospital, Fort Carson, Colorado

Evans ACH is a 57-bed hospital located in Colorado Springs, Colorado, and under the WRMC. It is part of an eMSM shared with the Air Force (U.S. Air Force Academy and Peterson Air Force Base). Evans ACH has an eligible beneficiary population of 72,811, of whom 62,389 are enrolled; the two Air Force MTFs have an additional 100,000 eligible beneficiaries and 55,000 enrolled in the eMSM catchment area. It provides many general and specialized medical and surgical services, such as chiropractic, clinical psychology, dermatology, emergency services, gastroenterology, internal medicine, mental health, neurology, nuclear medicine, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, pediatrics, psychiatry, substance abuse, surgery, and urology. It does not provide cardiology, newborn care, nephrology, or pulmonology services. The closest trauma center is Memorial Hospital in Colorado Springs, 11 miles away. Evans ACH has 14 child MTFs (12 in Colorado and two in Utah) and is affiliated with several non-VA civilian hospitals located in the area. The civilian facilities provide some of the services not available at Evans ACH, such as cardiology and newborn care. In the data call, Evans ACH reported that three assigned urologists provide care at another Defense Health Program facility and at five non-VA hospitals, all for purposes of routine proficiency maintenance. We found five relevant agreements in the MEDCOM central repository.

William Beaumont Army Medical Center, El Paso, Texas

WBAMC is a 209-bed hospital, level III trauma center located in El Paso, Texas, and under the WRMC. It provides essentially all general and specialized medical and surgical services. The local beneficiary population is 84,292, of whom 70,261 are enrolled. The main

service it does not provide is newborn care. WBAMC has seven child MTFs—six in Texas and one in New Mexico—and is affiliated with five non-VA civilian hospitals and one VA medical center. Through the data call, WBAMC reported that 15 physicians, nearly all of whom are surgeons, practice outside their assigned MTF as individuals in non-VA hospitals and as teams in the VA hospital. Their relationship with the local (adjoining) VA medical center dates back many years, whereas their ERSAs are more recent, dating back only about two or three years. The agreements include specialists in obstetrics and gynecology, orthopedic surgery, urology, ophthalmology, otolaryngology, general surgery, and gastroenterology. They provide services outside their assigned MTF for various purposes: routine proficiency maintenance to maximize care provided to beneficiaries, but also because of limitations in auxiliary personnel and operating theaters and lack of robotic surgery capabilities at WBAMC. We found three relevant agreements in the MEDCOM central repository, corresponding to the three non-VA civilian facilities. The MTF provided four additional agreements during the project team’s site visit. MTF personnel also noted that they have about 500 agreements, mostly for GME and other training.

Common Themes from Stakeholder Discussions

In this section, we summarize the common themes—and some other unique findings—that emerged from discussions with key personnel at the military services and OSD. Because the site visits were essentially more-focused discussions about the same general questions used for individual stakeholder discussions, we synthesize the themes across all these discussions. We collected and analyzed expert experience and perspective to identify key themes and inform conclusions about how successful the practice of agreements between MTFs and VA or other civilian facilities is and how the practice might be improved in the future. In this section are the common themes that emerged from all of these discussions.

Stakeholders Overwhelmingly View External Agreements as Mutually Beneficial

Without exception, all stakeholders consulted—including MEDCOM and MTF command staff, MTF physicians, and counterparts at VA and other civilian facilities—support external agreements with VA and other civilian facilities, for several reasons. They cite many dimensions of benefit, including better access, quality, and continuity of care that they can provide to military beneficiaries and opportunities for Army medical practitioners to be exposed to industry best practices in civilian facilities and have access to sophisticated medical technologies that might not be available or justifiable in the MTF, which, in turn, serves a range of purposes, from pre-deployment readiness training to routine proficiency maintenance and better beneficiary care. They cite good community relations as another benefit.

Most of these key personnel also felt that the agreements could and should be continued and even expanded, including opportunities for more-open agreements and for medical personnel other than just physicians to work in such facilities, when justified by need, cost considerations, and mutual benefit. Nearly all MTF interviewees noted that ERSAs are relatively easy and quick to establish and easy to implement. In contrast, VA–DoD sharing agreements are more complex because they require a business case analysis and approval up two chains of command.

Medical Treatment Facilities Draw on Different Mechanisms for Military–Civilian Partnerships to Meet Readiness and Beneficiary Care Requirements

MTFs draw on different mechanisms to meet needs for medical proficiency and beneficiary care that they cannot fully meet within the MTF. These include medical care resource sharing from one end of the spectrum, across the military services through MSMs, to sharing with the federal VA system and non-VA civilian facilities. They also include formal training opportunities (through training agreements) and informal training opportunities provided when Army practitioners provide beneficiary care (e.g., through ERSAs) in civilian or VA facilities that have better patient mix, infrastructure, service availability, or

equipment than the MTF has. Our study focused on Army medical practitioners who provide beneficiary care or train in such facilities, i.e., outside their assigned MTFs. Although they were not a focus of our study, we also describe GME-related training agreements (which can be out of or into MTFs).

The U.S. Navy has a unique sharing agreement approach in the Great Lakes region, where a Navy hospital became a VA hospital and then became a joint VA–Navy facility in 2010.

The U.S. Air Force has taken a different approach from the Army’s in its sharing agreements and strategies. Because the Air Force has faced more downsizing and trended toward smaller MTFs, it might have a greater incentive to increase partnerships with civilian facilities, while also requiring medical skill training and maintenance for its combat medical support mission. Like the other services, the Air Force sends medical providers for training in trauma centers (in Baltimore and Tampa), but, for other skill maintenance and for providing beneficiary care, it has an even closer relationship with non-MTF partners. For example, in Colorado Springs, several Air Force providers are *embedded* in partner facilities on six-month rotations, where they treat both military and civilian patients.

Most Agreement Types Are Supported by Ample Authority, but the Currency and Comprehensiveness of Guidance Is Uneven Across Different Types

As noted in Chapter Two, statutory authority and DoD and Army-level guidance support the various types of agreement. Guidance is the most recent, clear, and comprehensive for VA–DoD sharing agreements, while guidance is least comprehensive for ERSAs and most outdated for GTAs. During site visits, commanders generally commented that they have the authority to enter into agreements but also noted that guidance is old and in need of updating. In sharp contrast to the comprehensive and current nature of VA–DoD sharing agreements, the non-comprehensive and outdated nature of guidance for ERSAs and GTAs might be due to lack of active proponents for such agreements. In the absence of active proponents and given the decentralized nature of these agreements, the onus falls on MTF leadership to be aware of

their availability and potential benefits. The MTFs at all four sites we visited employed one or more such agreements, so were clearly aware of them. Probably because of the targeted nature of our headquarters-level consultations, all of those stakeholders were also aware of these mechanisms; nonetheless, they shared the view that guidance is old and in need of updating.

Army Agreements Most Commonly Address Medical Treatment Facility Capability Shortfalls in Providing Care to Beneficiaries

At all four MTF sites we visited, the agreements were primarily intended to address some shortfall in the MTF in providing care to beneficiaries; this was usually that the MTF had inadequate operating room, obstetric delivery, or intensive care capacity or lacked sophisticated equipment, but it also included the lack in MTFs of highly specialized ancillary staff for particular needs. In several cases, the technology that the civilian facilities offer was superior to what was available (and justifiable) at the MTF—notably, robotic surgery capability. Not only do these capabilities offer much-desired training or skill maintenance for MTF physicians in particular, but one can credibly claim that these capabilities increase beneficial patient outcomes. Accordingly, MTF leadership and practitioners often indicated that using these agreements decreased patient wait times, improved quality of and access to care for beneficiaries, and enabled military physicians to use modern medical technologies to care for beneficiaries in civilian facilities. Having MTF personnel use these agreements to treat eligible beneficiaries enabled those patients to be somewhat more closely maintained in the MHS direct-care system instead of, as some noted, “[being lost] completely to the network.”

The converse is also true, particularly in the case of VA. In some cases, VA does not have the inpatient or operating room capacity required. For example, in both El Paso and Colorado Springs, the VA facility is only an outpatient facility, and more-intensive VA services would require transport to a larger VA facility in other cities. Therefore, the agreement between MTFs and VA sometimes results in VA patients being treated and admitted at the MTFs. In both instances, the DoD MTFs had more local capacity needed to care for VA beneficiaries. (In

Colorado Springs, this agreement was with the Air Force MTF for the use of the latter’s ambulatory surgery capacity.)

The Origin and Management of Agreements Are Mostly Decentralized

Stakeholders at both headquarters level and the four sites we visited indicated that agreements, especially for military practice in non-VA civilian facilities, arise independently at each MTF, based on local needs. Indeed, Army MTF commanders have the authority to enter into ERSAs without MEDCOM review or approval. And the format or template for such agreements tends to be MTF-specific, i.e., ERSAs from the same MTF look virtually identical to one another but different from the ERSAs that other MTFs develop. From examining the 19 available ERSAs and comments made during our various stakeholder discussions, we see at least two distinctly different approaches to structuring ERSAs: Although all ERSAs are intended to provide care to eligible beneficiaries in non-VA civilian facilities—typically highly specialized care that cannot be provided at the MTFs—some agreements specify the specialty and even the provider (sometimes one agreement for each provider), whereas others are intentionally general so they can stay in place longer, without requiring modification as providers rotate into or away from the MTFs.

Nearly all observers felt that the MTF locus of management responsibility was appropriate for ERSAs. Nonetheless, at least one senior Army medical officer commented that he felt that there had been no “umbrella guidance” for undertaking such agreements when he had been the MTF commander in a previous assignment. Furthermore, given the decentralized nature of most agreements, there appears to be no single place where all agreements can be found—they are scattered across MTFs, RMCs, and the MEDCOM repository.

Most Agreements Involve Only Physicians

Most current Army medical practice outside MTFs involves *physicians*, mostly surgeons, who provide care to beneficiaries, usually as *individuals* rather than as part of a team. Very few agreements involve nurses, medical technicians, or other medical personnel. However, in at least

one site that already uses ERSAs extensively for physicians, both MTF personnel and their civilian counterparts indicated that they had not given sufficient thought to enlarging the range of Army medical personnel who take advantage of opportunities to provide care in the civilian facility, but they intend to consider such expansion in their future planning. Related to this, they also indicated that expansion of types of personnel might also include their participation in such agreements as teams, rather than just individuals.

Few Local Agreements Target Trauma Training to Improve Combat Medical Readiness

A key MHS mission is to be prepared to treat combat injuries in deployed environments and to support MTFs for higher-echelon care. Thus, the skill mix required for these missions can be quite different from that needed for treating a garrison population of active-duty soldiers, dependents, and retirees. Our discussions indicated that the Army and other services meet this need almost exclusively through agreements with a small number of designated trauma centers, where military providers gain experience in treating such traumatic injuries as gun and stab wounds. In particular, FSTs do rotations at these facilities mainly for pre-deployment readiness.

The Army uses centers in Miami (civilian) and Houston (military) for such training.

Surprisingly, our discussions revealed no example of an individual agreement between an MTF and a local trauma center to provide such experience, whether for pre-deployment or routine proficiency maintenance purposes. And through the data call, only two MTFs reported pre-deployment skill augmentation as a reason that any of their personnel worked in local civilian facilities. Moreover, for only one of these MTFs were the reported agreements consistent with this. For the other MTF, the two reported agreements clearly would not serve this purpose. Indeed, most of the agreements that MTFs reported and were available through the MEDCOM repository were ERSAs, which are exclusively for providing care to beneficiaries. We saw little documentation and heard nothing during our discussions about training agreements with civilian teaching hospitals, which would enable Army med-

ical personnel to care for civilian patients in a training context. Such agreements might be especially pertinent for maintaining trauma care skills in a local setting (rather than just the team-based pre-deployment rotation through the Ryder Trauma Center in Miami).

Agreements Can and Do Provide Myriad Benefits

In addition to meeting shortfalls mostly at MTFs or VA facilities, the agreements are viewed as providing significant other benefits to DoD, VA, and civilian medical systems, typically mutual benefits. These include the following benefits.

Perceived Cost Savings to the Department of Defense

ERSAs enable military medical personnel, whose salaries DoD already pays, to provide direct care to military beneficiaries. In the short-term current context that was the frame of reference for stakeholders in their comments, they perceived that such arrangements help avoid some costs to DoD or TRICARE because the civilian facility cannot charge for the military provider in its billing to TRICARE.

Revenue Generation and Better Utilization of Civilian Hospital Capacity

From the civilian perspective, beneficiaries represent a source of hospital revenue, even when active-duty providers are involved. Civilian organizations charge MHS (through TRICARE) at standard rates, but they cannot bill for the military provider, whose salary DoD has already paid. At the same time, the military providers and beneficiary patients help to more productively use the civilian hospital's capacity, such as operating rooms and expensive equipment, which are billable and hence generate additional revenues for the facility. At one site we visited, the civilian medical community depends highly on the beneficiary population and has been able to invest in infrastructure and equipment that serves both beneficiary and non-beneficiary patient populations. As one civilian hospital leader said, "We won't get rich off these agreements, but they're fair and it's the right thing to do."

Access to Industry Best Practice—Skill Proficiency and Productivity

The benefit that MTF leadership and particularly physicians cite most often is that agreements allow physicians (and, in more-limited cases, other providers) to maintain their skills on par with their civilian colleagues. This is realized in two ways: ensuring an adequate case load and mix when these are not available at the MTF, and maintaining proficiency on cutting-edge technology that is sometimes not available at the MTF (e.g., robotic surgery). We spoke with several military physicians involved in such agreements. They all commented that the productivity achieved in their treating beneficiaries in civilian facilities was higher than at MTFs. In some cases, this is because the patient population seen at the MTF is too low to maintain the number of cases that individual physicians need to maintain skills and certifications. For example, in several cases, surgeons described “double scrubbing” in the MTFs: cases in which two surgeons would participate in a single surgery when one would have been sufficient so that both can take credit for the case, largely to meet the numbers that some medical specialty boards require for certification or recertification.

The physicians cited readily available and highly trained civilian ancillary staff and a business-centered incentive for civilian facilities to make facilities and equipment available for a higher caseload in civilian facilities. In many cases, for example, civilian facilities make operating rooms available on short notice and would often open additional ones so that a single physician could be more productive by moving quickly from one operating room to another. There were numerous examples of military physicians treating more than three times the number of cases per day in civilian facilities than seen at the MTFs.

Military providers often noted that the VA beneficiary population provides a more diverse case mix than does the typical MTF patient population; such case mix is another important dimension that is at least desirable and sometimes required for specialty board certification or recertification. Active-duty military beneficiaries and their dependents generally represent a younger and healthier population: For example, orthopedics to treat training and sports injuries are disproportionately high in this population compared with treatment of chronic health conditions. Although military retirees are a substantial

patient population (in some catchment areas more than others), this population is still distinct from the VA population, which is reported to have a higher proportion of complex, chronic illnesses and complications. Military physicians felt that the opportunity to treat this population contributed to their proficiency development and maintenance.

Provision of Complex Medical Care to Beneficiaries

Three of the four sites we visited have multiple ERSAs. At all these sites, the command group and the individual practitioners noted that their ability to work in a civilian (“downtown”) hospital enabled them to provide complex care to beneficiaries, which they could not provide in their assigned MTFs. They commonly cited access to intensive care units or sophisticated surgical equipment and ancillary staff as examples of this.

Access and Quality of Care

Primarily because of the reported higher productivity in civilian facilities, MTF staff and providers cited many examples of significantly decreased wait times for patients requiring care, such as surgery. In some cases, the reduction in delay was significant. This applied also to the VA population in cases in which MTF staff and facilities were used to treat VA beneficiaries, thus helping to significantly reduce the recently much-publicized VA backlog for treatments, such as colonoscopies. Less commonly reported but also significant was the perception that outcomes were also improved because of the agreements. This could be the result of reduced wait times and advanced facilities and technologies available through civilian partners.

Continuity of Care and “Recapture” of Military Beneficiaries into the Military Health System

In the emerging model of patient-centered medical care, *continuity of care* refers to care provided over time, through several encounters between provider and patient. Examples include pre-operative to surgical and post-operative care or pre-natal to obstetric and post-natal care. At the four sites we visited, MTF leaders and practitioners noted that ERSAs enable military physicians to care for beneficiaries through this entire cycle: An Army physician can see the beneficiary pre-operatively

at the MTF, provide surgical and immediate post-operative care at the civilian facility, and then see the patient back at the MTF for follow-on post-operative care, physical therapy, and so on. Both physician and beneficiary value such continuity of care—the latter because the beneficiary can see “his or her own doctor” and feel cared for by the MHS throughout all these encounters. Such arrangements are also beneficial to the MHS overall because they help reduce the “leakage” of beneficiaries to the civilian sector; with such agreements, beneficiaries receive most of their care in the MTFs and only more-specialized care in the civilian facilities.

Contingency or Backup for Patient Overflow or When the Medical Treatment Facility Is Temporarily Degraded (Such as for Facility or Equipment Repairs)

At one of the sites we visited, the command group noted that it drew on sharing agreements in temporary situations, such as when the heating, ventilation, and air conditioning system was being replaced or the operating rooms were being upgraded.

Efficiencies from Shared Services, Equipment, and Personnel

Particularly in MSMs, military providers and administrators indicated that they realize efficiencies in some services that cross institutional boundaries with the agreements, particularly in laboratory and pharmacy services, which have streamlined both operationally and contractually. The market approach has resulted in consideration of some services that one particular provider organization based on its patient population might not justify. Similarly, there is a trend to integrate other services, such as operating rooms. For example, one MTF might have operating room capacity while another MTF or local VA facility has ambulatory surgery capacity; providers from each facility can use the complementary capacity of the other. Equipment is also shared in some cases, notably including the use of robotic surgical suites at civilian facilities in catchment areas where the MTFs cannot justify the cost of such equipment. Finally, various stakeholders noted instances in which a specialist physician (e.g., neurosurgeon) was shared across institutions, when that specialty could not be justified solely by the

MTF or its VA or civilian counterpart but could be justified based on a pooled patient market.

Possible Incentive (or Disincentive) for Personnel Retention

In most cases, military providers indicated that the agreements increased their job satisfaction by enabling them to see more and more complex cases in state-of-the-art facilities; bringing those skills back to the MTFs can add to the quality of military medicine, with a potential effect of improving (or at least preserving) retention rates. From this perspective, providers viewed command support of the agreements as very favorable. However, some offered the “grass is greener” argument as a possible disincentive to stay in the Army. To use the phrase of one, “Being unencumbered from all non-medical stuff I do at the MTF when I’m at [a civilian facility] is liberating. I get to be a doctor. [The civilian facility] treats me like a doctor.” Several physicians clearly stated that they see their experience in civilian facilities as a stepping stone to a civilian career, either before or after retirement eligibility. Indeed, we spoke with both current active-duty providers who were explicit about their intentions and former military medical personnel who had already made such a transition to the civilian side. Understanding the true proclivity of military physicians to leave the military early because of their experience with these agreements would require a carefully structured survey study.¹

Benefits to the Department of Veterans Affairs and Its Beneficiaries

Army medical professionals who care for VA patients are helping to reduce the VA backlog. At two sites visited, the Army MTFs are the source of local inpatient care for the local VA because the VA medical center (hospital) in each instance was in a larger city many miles away.

¹ It should be noted that “moonlighting” is still common; this practice of military physicians providing care for pay at civilian hospitals during their off-duty time was not a focus of this research. There are different legal considerations, such as state licensure. We did not see evidence of moonlighting being either supportive or detrimental to resource-sharing agreements and note that the potential effect of agreements on retention discussed above is likely not new because the same effect is likely to have already been seen through moonlighting practices.

Military–Civilian Relations

A common theme of discussions during the site visits, with both military and civilian leaders and providers, was that the agreements have been very beneficial in fostering a cooperative environment among the military and civilian medical communities in these cities. We were told often of the view that there is no longer an “us–them” perspective but a “whole medical community” attitude, including the MTF, civilian, and VA facilities. This attitude applies not only to providers but also to leaders and administrators and is frequently characterized by various collaborative teams for planning, operations, and, perhaps to a lesser degree, oversight. Although the agreements formally promote this community approach, there are several examples of ancillary benefits, particularly among the physician community, as characterized by a reported increasing amount of formal and informal consultation across military and civilian boundaries.

Graduate and Continuing Medical Education

Although we were asked to specifically exclude GME from our consideration of agreements in this study, discussants raised the topic so often that it requires some mention. Leaders and providers at the two AMCs we visited consistently said that, without the agreements, GME programs—medical school education and medical residency training—would be either difficult or impossible to support at their current levels, particularly in general medicine. In some specific cases, GME is founded primarily on military medical residents training in civilian facilities. More generally, the overwhelming perception is that the skill acquisition and proficiency that senior physicians gain through the external sharing agreements contributed importantly to their mentoring of GME programs.

Liability Coverage and Hospital Privileging Are Not Impediments to Military Practice in Civilian Facilities

Stakeholders broadly confirmed our finding from analysis of documents that there is sufficient liability coverage through several mechanisms so as not to impede the current—and, most likely, future—agreements. Moreover, very few stakeholders, including those at the

four sites visited, indicated common or significant impediments for MTF physicians to obtain the hospital privileges that permit them to practice in the hospitals.

There Are Some Challenges in Executing Current and Future Agreements

The various types of agreements we examined are predominantly viewed as favorable. In no case did any stakeholder from any organization suggest that the practice should be discontinued. In fact, those suggesting that agreements be expanded far outnumbered those recommending the status quo. However, difficulties remain in some aspects of the execution of agreements, and, without systemic changes in some cases, these difficulties are likely to persist in existing and future agreements.

Real-Time Access to Patient Records

Not surprisingly, the different IT platforms that MHS, the VA system, and civilian facilities use do not communicate seamlessly. This primarily results in a lack of real-time visibility of patient information and records and the inefficiencies of manually transferring information from one system to another as a patient is cared for through different systems. Many examples were cited of patient treatment being delayed or not performed because physicians could not review records in a timely fashion. The incompatibility of systems is seen in other ways also, including, for example, the inability of a physician from one organization to place orders for medicines or procedures in another organization's system. Although the sample is small, it seems evident that these issues are more pronounced in the military–VA relationship than with civilian agencies, which seem more adaptable to workarounds or fully privileging military physicians. However, even when the military physician is fully privileged in a civilian facility (which TRICARE guidance for ERSAs requires), the workarounds do not necessarily extend to seamless patient record-keeping between that facility and the home MTF where the beneficiary might receive most of his or her care (e.g., primary care and pre-operative and post-operative follow-up care). However, at two sites, local stakeholders were trying to work through these problems by all participating in a locally developed

health information exchange. The development of health information exchanges is supported nationwide through grants to states from the U.S. Department of Health and Human Services, within the context of emergency preparedness and response.

There were as many examples of workarounds as there were problems. However, the larger solutions will probably come from policies, practices, and standards to enable smoother operations across systems, rather than a series of local “fixes.” In the meantime, local data-sharing solutions, particularly between MTFs and VA facilities, include informational exchange “viewers” that are used so a patient record can be viewed but not altered. In some cases in which the facilities are collocated or nearby, “sneaker net” is often used: A runner transports the records on paper. In cases in which physicians do not have permissions to place orders on another facility’s system, some advance planning is required; for example, a surgeon might place post-operative prescription orders on his or her home facility system so they will be available where the surgery is actually performed. This practice, of course, carries a risk that complications during or after surgery will require different prescriptions. In other cases, it was noted that the inability to place orders in a hosting facility system can have significant consequences for access to needed operative care. For example, a pre-operative examination could indicate a required consultation (e.g., cardiac examination), but delays in ordering that consultation could sometimes result in the consultation not occurring in time for the scheduled surgery. Further, because of differing standards (particularly between MHS and VA), the thresholds for needed consultations might be different, and a consultation needed at the last minute can result in sending the patient back to the host institution instead of having the consultation done at the facility that has already received the patient for surgery.

Lack of Uniformity of Clinical Care Standards and Procedures

When different well-established systems wish to work together, it should not be surprising to find that the clinical standards and procedures for each are different. Of the two sites that commented on this, both indicated that counterparts from the two sides were working collegially and collaboratively to resolve or reconcile such differences.

Caseload Credit

Another issue related to practice in a VA or other civilian facility is which institution receives “credit” (relevant to productivity monitoring and billing) for a patient visit or procedure, e.g., performed by an Army practitioner outside the MTF. The small sample size of this study does not support a thorough review of this potential issue, but several different people noted that how credit should be allocated can be unclear: for example, based on who performs a procedure, where it is performed, or using which organization’s equipment. In each case in which this was presented, it was also noted that this issue has been addressed either in specific cases or as a workaround for an agreement, but there seems to be no systematic policy or process for this determination. Two knowledgeable military medical administrators who understand ERSAs and have overseen them in operation suggest, for example,

- If an active-duty provider sees an active-duty beneficiary at a VA or civilian facility (referred by the parent MTF), the referring MTF gets the workload credit and the VA or civilian facility is compensated for space used.
- If an active-duty provider sees a TRICARE beneficiary at a civilian facility, the referring facility gets the workload credit. The active-duty provider’s time can be adequately recorded in the Medical Expense and Performance Reporting System.
- If an active-duty provider sees a VA beneficiary at a VA facility, the VA facility gets the credit. The active-duty provider’s time can be adequately recorded in the Medical Expense and Performance Reporting System and covered under professional training.

State Licensing Requirements

A military medical practitioner must have an active license from a U.S. jurisdiction (10 U.S.C. 1094; Under Secretary of Defense for Personnel and Readiness, 2013a, Enclosure 4, Section 1.5.b.1; Headquarters, Department of the Army, 2009, ¶¶ 4-4–4-5). This license enables the practitioner to work in any MTF. However, it might or might not enable the practitioner to work in a civilian hospital. In some instances, the state medical board might require the provider to have a state license to

be *credentialed* to work in a civilian facility. This appeared to be more the case for nurses than for physicians. Physician *privileging* to work in the hospital is up to each hospital, which takes several factors into account in granting specific hospital privileges to a military physician. As noted above, hospital privileging did not appear to be an impediment to civilian hospital practice, at least for physicians working under ERSAs.²

Local Logistics and Lost Productivity

Although we expect that this is more broadly the case, personnel at one of the sites we visited commented that driving times between the MTF and the VA or civilian “downtown” facility meant lost time and lost productivity. For example, surgeons must conduct daily rounds on their post-operative patients in the civilian facility and might need to make additional patient visits if problems arise. This becomes even more problematic for civilian facilities that are not in the same town as the MTF and could be a reason for minimizing the actual use of ERSAs that are in place with facilities that are not conveniently located.

Unintended Consequences of Agreements on Medical Treatment Facility Proficiency and Readiness

Without exception, physicians view agreements favorably, and MTF and higher-echelon leadership support the agreements. However, many physicians’ favorable views are often noted to be the result of what is perceived as more trained and available staff and facilities in civilian institutions. Because the vast majority of agreement execution involves only a military physician and not military nurses or ancillary staff, the physician could benefit in the area of skill maintenance as he or she provides care to military beneficiaries in a civilian facility—and can bring those skills back to benefit the MTF—but the rest of the MTF staff does not receive this opportunity. It was noted that this could present a circular problem over time: As the number of beneficiary cases that physicians see outside the MTF increases, the caseload of the MTF could decrease. A decrease in MTF caseload or complexity of cases could be detrimental to the proficiency maintenance of

² The majority of ERSAs reported and examined were for physicians.

non-physician MTF staff. A more-comprehensive review of caseload and mix would be required to determine whether this trend actually exists and could exist in the future and how it could affect MTF readiness and proficiency overall. If this issue is determined to be pertinent, future agreements might need to consider how to better involve non-physician staff in the benefits that the agreements offer to the MTFs.

Conclusions and Recommendations

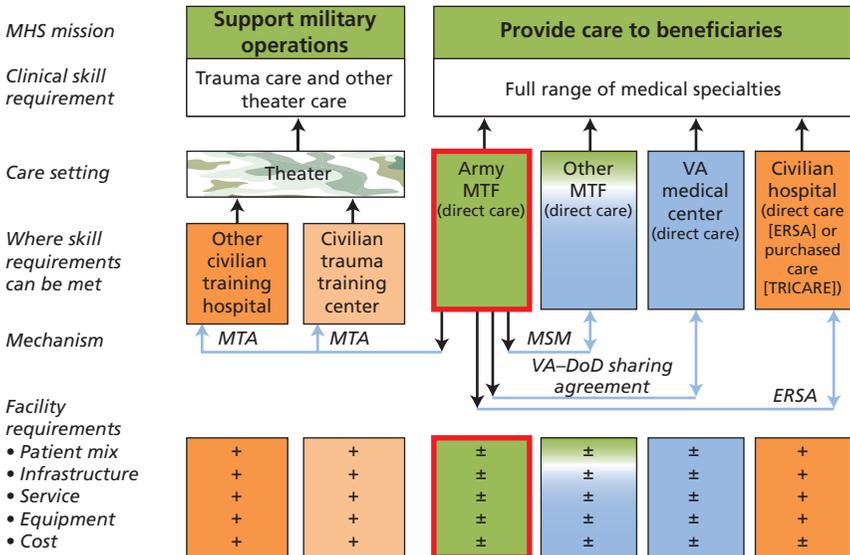
MHS continues to enhance the efficiency and quality of care to meet its two missions of supporting military operations and providing beneficiary care and to meet its four aims of readiness, improved population health, better experience of care, and lower per capita cost. As it does so, it grapples with balancing direct and purchased care and maintaining clinical proficiency. Although DHA policy is increasingly reoriented toward “recapturing” beneficiaries for care within MTFs, different types of agreement enable some degree of direct care outside an Army MTF—in the MTFs of other services (in the eMSMs), in VA medical centers (through VA–DoD sharing agreements), and in non-VA facilities (through ERSAs and MOAs). By statute, providing care to beneficiaries in a civilian facility is intended to improve access, effectiveness, and efficiency of care.

The study found that management of external medical practice is largely decentralized and context-specific: Each MTF develops its own business plan, taking into account the local profile and alignment between MTF supply (assigned personnel, facilities, services), local beneficiary demand (at the MTF and in the broader local catchment area), training needs of MTF personnel, and cost considerations. As described in Chapter Two, the relevant statutes indicate that the goals of resource-sharing agreements with both the VA and non-VA civilian facilities are to provide care to beneficiaries more effectively, efficiently, and economically and, in the case of VA sharing agreements, to increase access to care. The goal of training agreements is to provide opportunities to build or hone clinical skills in civilian facilities,

whether for deployment-related purposes or simply to maintain clinical proficiency. With these foundational premises, highlights of the findings related to MTFs, agreements, and stakeholder discussions follow.

Figure 6.1 summarizes the business planning landscape for MTFs (their centrality is indicated by bold red outline in the figure): the clinical skill requirements to meet the MHS missions, the care settings in which those requirements could be met, the mechanisms Army MTFs can use to access those settings, and the requirements for such facilities—patient mix, infrastructure, services available, equipment, and cost optimization. All of these contribute to MTFs’ decisions about where and how they can best meet their various mission-related requirements. For example, civilian hospitals, including trauma training centers, typically have adequate patient mixes in terms of numbers and complexity; infrastructure (e.g., operating room, intensive care);

Figure 6.1
Factors Guiding Army Medical Treatment Facility Decisions Regarding External Practice



NOTE: + = adequately meets requirements. ± = might or might not meet requirements.

services available (e.g., emergency, obstetric delivery, inpatient); and equipment (e.g., diagnostic, surgical)—all reflected as “+” in the figure. For gratuitous training agreements with such facilities, cost considerations are also favorable (such agreements involve no exchange of funds). Each Army MTF might or might not meet the full complement of facility requirements—reflected as “±” in the figure. An MTF that can meet all needs within the MTF might not need to seek civilian partnerships. However, those that lack any of these critical features might need to meet shortfalls through one or more mechanisms described in this report. Their choice of partner will depend on the presence and characteristics of other local facilities, as well as cost considerations.

Thirteen of the 28 Army MTFs reported external medical practice, and nearly all of these reported using ERSAs for military professionals to provide beneficiary care. As reported, far fewer use VA–DoD sharing agreements, GTAs, or MOAs. However, as noted earlier, there is reason to believe that reporting from the MTFs might have been incomplete, especially for ERSAs.

MTFs using the various types of agreement and other Army experts universally endorsed such arrangements and noted numerous specific benefits to the Army. They cited such benefits as better access, quality, and continuity of care that they can provide to military beneficiaries and opportunities for Army medical practitioners to be exposed to industry best practices in civilian facilities and have access to sophisticated medical technologies that might not be available or justifiable in the MTF. They cite good community relations as another benefit.

Stakeholders cited only a few challenges in providing care to beneficiaries in civilian facilities, such as lack of interoperability of patient records and difference in clinical care standards and practices. Given the attention to liability considerations and the Department of Justice rulings documented well in materials reviewed, we had anticipated that malpractice liability, as well as credentialing of physicians in a local civilian hospital, might pose challenges; however, as the various stakeholders reported, these do not appear to pose major barriers. One of the greatest challenges is the lack of interoperability of patient medical records across systems, mainly MTF–VA and MTF–civilian,

which creates inefficiencies, including delays in care delivery and time-consuming manual transfer of patient information.¹ Some sites are creating workarounds to address these issues. Systemic fixes that apply more broadly, within a local area or even across the country, would be highly desirable. Another perceived challenge raised at one site and in other interviews is the lack of uniformity of clinical care standards and procedures—for example, between MHS and VA facilities.² However, at one site we visited, both MTF and VA personnel interviewed noted that they recognized this and are working to standardize these satisfactorily, upward through the chain of command on each side.

An administrative challenge is clarifying who gets “credit” (for TRICARE reimbursement and productivity monitoring purposes) for care that a military practitioner provides in a facility outside MHS. Updated guidance can specify this more clearly.

Most of the 15 MTFs that did not report using ERSAs or VA resource-sharing agreements indicated that their *routine and deployment-related medical readiness needs* were met at their MTFs, suggesting little need for additional training, such as that afforded through GTAs. We did not ask MTFs specific questions about their assessments of *beneficiary needs* that could be met productively outside the MTF through resource-sharing agreements or whether MTFs were even aware of the various mechanisms available to them for such purposes. This is because early discussions with OTSG staff and review of documents had suggested that training and deployment-related proficiency enhancement were likely to be the main reasons for external practice in civilian facilities. There was no indication at the time that ERSAs, used mainly for physicians on an individual basis, would be as prevalent and universally acclaimed as they ultimately were found to be. We did not ask the MTFs specifically about whether they had considered the need for and benefits of extending ERSAs to disciplines beyond physicians or to teams of military professionals. However, one MTF visited and its counterpart civilian facility indicated that they had not

¹ This was a problem that GAO reported in its September 2012 report, noted previously (GAO, 2012b).

² GAO also noted such a problem in its 2012 report (GAO, 2012b).

given this enough thought but intended to consider the possibility of such expansion in future business planning. The benefits of and broad acclaim for such agreements from those who use them suggest that any untapped opportunities should be identified and that MTFs should be encouraged to take advantage of them if they are justified in the MTFs' business plans. Thus this study sets the qualitative foundation for more-focused analysis in this direction.

For two important types of agreement (ERSAs and GTAs), military stakeholders from local to headquarters level emphasized that guidance is outdated and less than comprehensive. Even those at MTFs that use such agreements indicated their desire that the guidance be updated. We found limited guidance for ERSAs, only in *TRICARE Operations Manual* (TRICARE, 2008), and the OTSG/MEDCOM memo from 2000 addressing GTAs is both limited and outdated (OTSG, 2000). Moreover, it does not appear that there is a designated proponent for either of these types of agreement. Although our study did not quantify how familiar MTF leaders are with these agreements, clearer guidance and an active proponent should serve to raise awareness so that MTF leaders can make fully informed business decisions about how they will meet clinical skill requirements and provide beneficiary care most cost effectively. The 2014 OTSG/MEDCOM memo 14-059 (Fiore, 2014) and the subsequent 2015 updated version (OTSG/MEDCOM memo 15-022) (Fiore, 2015) revising guidance for VA–DoD sharing agreements might be good models for updating guidance on these other agreements. Such future guidance might specify procedures for the development, approval, renewal, and documentation of agreements and provide relevant templates, such as for CONOPS or for the agreement itself (e.g., to include mandatory language related to liability coverage). Such guidance would be intended to help raise attention about such agreements (and the use of them) across more of the Army medical community.

The conditions that favor Army medical practice outside the assigned MTF appear to derive mainly from the local profile and alignment between each MTF's supply (of assigned personnel and available facilities and services), local beneficiary demand (at the MTF and in its broader catchment area), and readiness and other training needs of

MTF personnel. More specifically, MTFs that have adequate patient mix, infrastructure, services available, and equipment might not need to send personnel outside the assigned MTFs to meet mission-related requirements; however, MTFs where those features are absent or inadequate might have to meet shortfalls through agreements with other facilities. For example, the MTFs that use ERSAs do so when they have excess personnel capacity that can help meet local beneficiary demand that cannot be met at the MTF, such as when facility space (such as operating room or intensive care unit), medical service (such as obstetric delivery), or a specific technology (such as robotic surgery apparatus) is not available at the MTF.

All 13 MTFs use resource-sharing agreements mostly for physicians and, among them, mostly for surgeons across multiple surgical specialties. This is not surprising: Surgical practice tends to have facility and technology requirements that might not be available (or justifiable) at the MTF and that are more complex than what is required for the practice of many non-surgical specialties. MTFs enter into resource-sharing agreements with local VA medical centers when a business case analysis on both sides justifies the mutual benefit, such as reducing VA patient backlog in medical specialties for which MTF volume and mix are insufficient for the number of providers. Likewise, MTFs enter into training agreements when training needs cannot be met within the MTFs.

We conclude that there is strong consensus among users and leaders regarding the benefits of external medical practice and that such practice is warranted when the MTF and partner institution can justify it in their respective business plans. These conclusions suggest some recommendations for enhancing military–civilian medical synergies, which we describe next.

1. Update and expand Office of the Surgeon General and Army Medical Command policy guidance for external resource-sharing agreements and gratuitous training agreements

Regardless of the magnitude of any possible untapped opportunities to take greater advantage of these agreements, stakeholders at all levels, including those at MTFs that already use them, noted that current guidance is outdated, insufficient, and in need of updating. The detailed guidance contained in OTSG/MEDCOM policy memo 15-022 (Fiore, 2015) related to VA–DoD sharing agreements is a good model for the type of information and detail to be included (e.g., authorities, proponent, type of providers, type of patients, procedures for review and approval), as well as templates for CONOPS and the agreement itself, including any required language. Guidance for ERSAs could note the merits and disadvantages of specific (i.e., by name or specialty) versus more-general specifications in such agreements—e.g., the latter offering more flexibility and longevity beyond a current Army rotation. Update guidance might also specify how caseload “credit” should be determined. Finally, new guidance should also include authorities and relevant details associated with TRICARE regional offices and eMSMs.

2. Identify appropriate proponent for external resource-sharing agreements and for gratuitous training agreements

Proponents would assess and seek to optimize the benefits of current agreements, actively facilitate and support future agreements, and serve as a reference point across MEDCOM and potentially across all of MHS. The clearly identified proponent entity for DoD–VA agreements serves as an example of the value that might result from active proponents for ERSAs and GTAs.

3. In the short term, identify potential untapped opportunities related to different types of external practice, especially external resource-sharing agreements, and raise awareness to encourage their use when justifiable in medical treatment facility business plans

It will be important to first ensure that a clear understanding of the impact on clinical operations (e.g., cost, productivity, benefit delivery, continuity of care, safety, quality, and readiness) is documented in the MTF business plans. It will also be important to capture beneficiary data (e.g., *International Classification of Diseases*, 9th rev., codes) associated with care delivered in non-VA facilities by type of beneficiary and to document situations in which facilities and equipment are insufficient to deliver covered benefits. All such information should underpin analyses to justify military medical practice outside the assigned MTF or outside MHS.

Resource-sharing agreements were more prevalent than initially expected. We did not ask MTFs specifically about their assessments of the alignment between MTF capacity and local beneficiary demand. Nor did we ask whether they are even aware of the full range of resource-sharing and other agreements available to them. This report sets the qualitative foundation for more-focused efforts to identify and quantify any such untapped opportunities to further enhance MTF business planning and the quality and efficiency of care. Clear messaging about the availability, benefits, and challenges of the different types of agreement could encourage more MTFs to take advantage of them as relevant to their local context and business planning.

4. For longer-term policy purposes, conduct a quantitative assessment of the costs and potential efficiencies associated with care provided in the Military Health System compared with those in different civilian options, such as those examined in this initial qualitative study

Such analysis is needed to more fully understand the extent to which relationships with facilities outside the home MTF add value. Although past rigorous studies have led to the current state of MHS, including the results of the Base Realignment and Closure initiative, and the current mix of direct care (at MTFs and VA facilities) and purchased care (through TRICARE), further analysis is warranted to quantify the value of the various mechanisms for meeting mission requirements, from fully within MHS to fully within the civilian sector and multiple alternatives in between. The proposed analysis could include rigorous assessment of the cost-effectiveness of alternative approaches (e.g., relying fully on MTFs to meet all requirements and investing in infrastructure, services, and equipment as needed; relying fully on the civilian sector and scaling down MTFs accordingly; or various combinations of MTF and civilian practice and care that optimize costs and results); and analysis of the implications—including opportunity costs—that the various alternatives could have on MTF medical readiness (across all professional categories), patient care (e.g., safety, quality of care), patient outcomes, cost, perspectives of civilian providers, and perspectives of beneficiaries. The recommended assessment also needs to be against a desired CONOPS for MTFs (or types or tiers of MTFs). Standards of clinical practice are more important across DoD MTFs than across facilities in a given geographic area. Delivering a consistent, high-quality benefit, regardless of location (in MTFs or out in the “network”—across the entire enterprise) is desperately needed.

5. If such analysis warrants, encourage the expansion of agreements to include a wider range of Army medical professionals and medical teams

The majority of current agreements focus on the provision of care by military physicians, typically surgeons, working as individuals rather than as parts of military medical teams. As discussed above, we did not ask MTFs about the alignment between their supply of assigned personnel, including non-physicians, and local beneficiary demand. However, one site visited indicated an interest in considering non-physician personnel in their current or future agreements. Expanding the range of Army medical professionals—to include both physicians and non-physicians—who can provide care to beneficiaries or train in VA or non-VA civilian facilities could be beneficial for promoting and maintaining the proficiency of these individuals while also improving the quality and timing of beneficiary care. Such professionals can work in VA or other civilian facilities either as individuals or as parts of *teams* of military providers to maintain and improve their skills through these agreements. A team approach is currently used for pre-deployment readiness, such as when Army FSTs train and provide care at civilian trauma centers, but this practice could be expanded on a more regular and local basis through agreement practices already in place. However, there could be an unintended consequence of sending more professionals to provide care outside of their assigned MTFs. Transferring patient caseload from the MTF to a civilian facility could also pose some risk to the skill maintenance of other MTF personnel, including, for example, nurses and technicians.

6. Maintain the current scheme of decentralized management, but consider a mechanism for central visibility of agreements

Although there is little reason to alter the current decentralization of local agreements to MTFs and RMCs, there is potential benefit in having a central repository from which all agreements can be accessed

(e.g., MEDCOM or DHA level), for such purposes as policy analysis or operational or fiscal considerations. Through this study, it was clear that there is currently no single repository where all agreements reside. Periodic review of agreements could inform policy or practice in the ever-evolving MHS as it seeks to continually improve and ensure readiness, population health, health care experience, and cost of care.

7. Facilitate mechanisms to share experiences and learn lessons about different types of sharing and training agreements

Both Army RMCs and DHA TRICARE regional offices already play a role as central hubs for MTFs in their regions and for sharing ideas and lessons across regions. Active proponents for ERSAs and GTAs (recommendation 2) could provide added value with minimal investment by, among other responsibilities that could be assigned, reviewing and analyzing agreements within a central repository (recommendation 6) for purposes of informing policy and sharing experiences and lessons learned from implementation.

OTSG and MEDCOM officials might wish to consider additional ideas and suggestions that arose during our study, although we did not have sufficient data from our research to make concrete recommendations. The following issues might be worthy of further consideration:

- creation of a standard policy and system for determining productivity credit between the VA and Army
- encouraging the DHA to identify and facilitate mechanisms for better interoperability and efficiencies of patient medical records across different systems (MHS, VA, civilian). Where feasible, joint information and record-keeping systems for patient records and treatment activities would be beneficial to patient care, including continuity of care between MHS and VA and between MHS and other civilian facilities. Local civilian health information exchanges, such as that developed in Colorado, could be a model for better patient record-keeping along these lines.

- allowing local MTFs and VA medical centers to negotiate reimbursement rates locally, subject to approvals up one or both chains of command as needed, rather than being bound to nationally set rates. This could be tested on a demonstration or pilot basis, for example.
- reinstatement of the authorized practice of the Army paying for state professional licenses when required for the performance of official duties (Headquarters, Department of the Army, 2009, ¶ 4-5[a]). We noted frustration among a few military practitioners that the Army had discontinued this practice, although a state license is required for providing care under some ERSAs—i.e., where the state medical board requires a state license. We also observe that both the Navy and Air Force still pay for such licenses when they are required as a condition for the performance of official duties. Although it is understandable that the Army does not fund state licensure for the purposes of moonlighting, it seems that funding licensure to support MEDCOM-approved agreements might be warranted, particularly to support the overall economic benefit that the agreements intend.
- consideration and analysis of a potential system for the Army that includes “embedding” military health care providers in civilian or VA facilities, similar to the Air Force model.

Organizations Consulted

In addition to the U.S. government organizations listed below, this research benefited from consultation with several civilian medical care organizations, including partners of the resource-sharing agreements reviewed during the study and referred by MTF personnel during site visits:

- Assistant Secretary of Defense for Health Affairs
 - DHA
- OTSG and MEDCOM
 - Deputy Commanding General (Operations)
 - U.S. Army Medical Department Center and School
 - DoD VA program office
 - Army Medical Corps
 - Army Nurse Corps
 - Office of the Comptroller
 - Office of the Staff Judge Advocate
 - Office of Resource Management
 - Human Resources Directorate
 - IT/Business Office
 - RMCs: staff and subordinate facilities
 - DDEAMC
 - Evans ACH (Colorado Springs Military Health System)
 - GAHC
 - WBAMC
- U.S. Air Force
 - Defense Health Headquarters staff

- Office of the Staff Judge Advocate
- U.S. Air Force Academy
- U.S. Navy Bureau of Medicine
 - Office of the Staff Judge Advocate
- VA
 - hospital administrators and liaisons at site visit locations.

APPENDIX B

**Office of the Surgeon General and Army Medical
Command Policy Guidance on Department of
Veterans Affairs–Department of Defense Sharing
Agreements**

This appendix reproduces the OTSG and MEDCOM policy guidance on VA-DoD sharing agreements.



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL DEPARTMENT
2748 WORTH ROAD
JBSA FORT SAM HOUSTON, TX 78234-6000

REPLY TO
ATTENTION OF

OTSG/MEDCOM Policy Memo 15-022

10 APR 2015

MCZX

Expires 10 April 2017

MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL MEDICAL
COMMANDS

SUBJECT: Revised - Department of Veterans Affairs (VA)/Department of Defense
(DoD) Health Care Resource Sharing Agreement Development, Renewal and
Maintenance Process

1. References:

a. Title 38, United States Code, Section 8111, "Sharing of Department of Veterans
Affairs and Department of Defense Health Care Resources."

b. Title 10, United States Code, Section 1104, "Sharing of Resources with the
Department of Veterans Affairs."

c. Department of Defense Instruction (DoDI), 6010.23, Department of Defense and
Department of Veterans Affairs Health Care Resource Sharing Program, 12 Sep 05.

d. Joint DoD-VA Memorandum, subject: VA/DoD Health Care Resource Sharing
Rates/Billing Guidance Inpatient Services, 29 Aug 06.

e. Memorandum of Understanding between the Department of Veterans Affairs
and the Department of Defense, subject: Health Care Resources Sharing Guidelines,
31 Oct 08.

f. Outpatient Billing Guidance for DoD/VA Direct Sharing Agreements for Health
Care, 19 Aug 09.

g. OTSG/MEDCOM Policy Memo 13-064, subject: Joint Venture (JV) and Major
Sharing Sites (MSS) Operational Direction, 02 Dec 2013.

2. Purpose: To describe the process for approval of DoD/VA healthcare resource
sharing agreements.

*This policy memo supersedes OTSG/MEDCOM Policy Memo 15-016, 30 Mar 15., subject: Department of Veterans
Affairs (VA) Department of Defense (DoD) Health Care Resource Sharing Agreement Development, Renewal and
Maintenance Process.

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SUBJECT: Revised - Department of Veterans Affairs (VA)/Department of Defense (DoD) Health Care Resource Sharing Agreement Development, Renewal and Maintenance Process

3. Proponent: The proponent for this memorandum is the AMEDD DoD/VA Program Office, Health Care Delivery, MEDCOM G3/5/7; hereafter referred to as the Program Office.

4. Policy:

a. References 1a through 1f Department level guidance or guidance to the Military Service Surgeons General. Regional Medical Command (RMCs) and Military Treatment Facilities (MTFs) will refer solely to OTSG/MEDCOM policy for program planning, implementation, and evaluation. Unresolved questions will be adjudicated by the Program Office.

b. The DoD and VA may enter into direct care sharing agreements for the mutually beneficial coordination, use and exchange of healthcare resources of their Departments. The goal of sharing agreements is to improve access, quality, efficiency and effectiveness of the healthcare provided by the Military Health System and Veterans Health Administration to their respective beneficiaries.

c. Sharing agreements shall not adversely affect the range of services, the quality of care, the established priorities for care, or result in delay or denial of services to primary beneficiaries of the providing department. Additionally, sharing agreements shall not adversely affect readiness or the deployment capability requirement of DoD personnel.

d. This policy provides the authority, and approval process for local healthcare resource sharing of services, demonstrated by a Business Case Analysis (BCA) to be in the best operational and economic interests of both local parties.

e. Under 38 USC 8111, DoD/VA sharing agreements must be for the mutually beneficial coordination, use, or exchange of use of the healthcare resources of both agencies. If the RMC staff review determines the proposed agreement does not meet that requirement, other options such as an interagency agreement under the Economy Act may be appropriate.

f. This policy applies only to Resource Sharing Agreements, under 38 U.S.C. 8111. It does not apply to DoD/VA MOUs or MOAs for non-sharing matters, actions under the authority of the Federal Acquisition Regulation, interagency agreements under the Economy Act, DoD/VA Training Affiliation Agreements or other agreements as governed by DoDI 4000.19 (Support Agreements).

g. Requests for exception to policy will be referred to, and adjudicated by the Program Office, in consultation with other functional experts and the Staff Judge Advocate.

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5. Responsibilities:

a. The MTF, working with local VA partners, has the principal responsibility to identify mutually beneficial opportunities for improved healthcare access, quality, efficiency and effectiveness.

(1) Proposals of concept for local collaboration with VA will be described in a Concept of Operations (CONOPS) clearly detailing the mutual benefit and value of the proposal.

(2) The CONOPS will, at a minimum, address the topics included on the CONOPS template at Enclosure 3.

(3) A BCA following the G8 template will be developed that quantifies the value of the proposal as described in the CONOPS.

(4) Both the CONOPS and BCA will be provided to the RMC for review and validation.

b. The RMC Commanders are the preliminary approval authority for MTF-developed CONOPS and BCAs on proposed DoD/VA healthcare resource sharing agreements. Key consideration in the process is to determine if the proposal is in consonance with RMC vision and priorities. If the RMC supports the proposal, it will be transmitted to the Program Office with RMC Chief of Staff endorsement in writing.

c. The Program Office:

(1) After receiving the RMC approved CONOPS and BCA, will conduct an initial review of the proposal. The intent is to determine if the proposal fits the parameters of DOD/VA healthcare resource sharing policy (see references 1c-1g) and reflects mutual benefit to the local partners.

(2) During the review of the CONOPS, the Program Office will also obtain the G-8 position on the BCA and CONOPS.

(3) Make a recommendation to the G-3/5/7 regarding action on the proposal which may include: return to RMC for rework or support and obtain G3/5/7 support for further action.

(4) If G3/5/7 support is obtained, conduct initial coordination with the SANT and inform the sponsoring RMC to begin direct coordination with the SANT.

(5) After the SANT has successfully negotiated and prepared a final RSA document, develops a 540 staff action packet to obtain approval by the DSG.

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(6) Facilitates communication of DSG approval to the RMC, authorizing the RMC commander or RMC designee to sign the actual RSA.

(7) Obtains the signed RSA from the RMC and forwards to VACO for official VA agreement numbering.

(8) Returns the numbered agreement to the RMC.

d. The MEDCOM G-8:

(1) Conducts review of CONOPS and BCA to determine return on investment of the proposal to the MEDCOM.

(2) Indicates support; details changes needed, if any; or opposition to the proposal based on analysis conducted.

(3) Provides recommendations on the proposal to the Program Office.

e. The G-3/5/7:

(1) Receives the recommendation of the Program Office regarding disposition of the proposal.

(2) With concurrence of the proposal, directs the Program Office to work with G-33 Current Operations to task the MEDCOM Sharing Agreement Negotiations Team (SANT).

f. The SANT: A team of subject matter experts appointed on orders that possess the exclusive authority to negotiate sharing agreements on behalf of MEDCOM. The composition of the SANT is reflected in Annex A.

6. Procedures for New Agreements:

a. The MTF, after identifying cost effective opportunities for collaboration with local VA partners, will review the policies cited in references 1c-1g to determine if the proposal is in consonance with enterprise-wide policy. If the proposal merits, the MTF will develop and present a detailed CONOPS and BCA clearly delineating anticipated costs and benefits. This analysis will be presented to the RMC for review and validation.

b. The RMC will conduct a secondary analysis of the MTF proposal to determine if it is in consonance with RMC vision and priorities. Careful consideration will be given to each of the following staff domains: Managed Care; Patient Administration; Resource

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Management; MEPRS; Human Resources; Logistics/Facilities, and Information Management/Information Technology. If the RMC supports the proposal, it will be transmitted to the Program Office reflecting RMC Chief of Staff support.

c. The Program Office, after receiving the CONOPS and BCA, will conduct an initial review of the proposal in concert with G8. Once the review is complete, the Program Office will:

- (1) Seek additional information from the RMC if required.
- (2) Make recommendation for modification.
- (3) Make a recommendation to the G3/5/7 on the disposition of the proposal.

d. The G/3/5/7 will review the Program Office's recommendation and render a decision. If the proposal is supported, the G3/5/7 will direct the Program Office to initiate the MEDCOM process for new agreement negotiation.

e. The Program Office, after receipt of the G3/5/7 decision on the proposal, will have the G33 notify the USAMEDCOM Sharing Agreement Negotiation Team (SANT).

f. Working with the G33, the RMC and the SANT, the Program Office will identify a window for the SANT to deploy (actual TDY or VTC) to the MTF to conduct negotiations with VA on the agreement proposal. During the TDY period the SANT will refine the proposal concept and draft an RSA and negotiate with VA to secure the agreement. If an agreement cannot be reached, no further action will be taken on the proposal.

g. If negotiations are successful, the Program Office will task the MEDCOM staff to conduct a final review. Once all MEDCOM staff required to comment report concurrence, the agreement 540 packet will be prepared by the Program Office for a final decision by the Deputy Surgeon General.

h. Once DSG approval of the agreement has been obtained, the Program Office finalizes the process for MEDCOM as detailed in para 5c, above.

7. Renewals: Provision of services requires a current sharing agreement.

a. The process for agreement renewal begins with the submission of an updated CONOPS and BCA prepared by the MTF. In coordination with the RMC, these products will be sent to the Program Office for a review not less than 120 days prior to agreement expiration.

MCZX

SUBJECT: Revised - Department of Veterans Affairs (VA)/Department of Defense (DoD) Health Care Resource Sharing Agreement Development, Renewal and Maintenance Process

b. Agreements that require modification, additions or amendments will be deemed new agreements, and follow the process described in paragraph 6, above. Once the regional headquarters transmits the CONOPS and BCA to the Program Office, the Program Office will determine if new negotiations are required to secure an appropriate agreement renewal.

8. Evaluation and Compliance

a. The RMC will maintain a comprehensive, up-to-date database of all current and expired agreements. The database capabilities will support queries based on the following criteria: by participating MTF and/or Veterans Administration Medical Center, agreement number, agreement type (e.g., Master Sharing Agreement, Amendment, Renewal), services provided, and the start and end dates of the agreement. Each file for active and expired agreements will contain all documentation related to the agreement, generated throughout the agreement's life cycle. This includes the initial financial analysis or BCA, staffing documents, annual reviews, performance-based objectives/metrics, and all previous versions of the agreement. In addition to supporting RMC requirements, the database will ensure the RMC can support timely responses to requests for information from OTSG, DoD, Congress, and other external stakeholders.

b. Per reference 1.g., RMCs will ensure their Joint Venture and Major Sharing Sites (reimbursable services > \$1M annually) report financial performance quarterly to USAMEDCOM G8, Finance and Accounting Division (MCRM-F) using the format at Enclosure 2.

c. The RMC will annually conduct a detailed operational and economic analysis to assess the utility and value of each agreement. Confirmation that this analysis was performed will be reported to the Program Office through the AMEDD DoD/VA Program Office website, no later than 30 days after the start of the fiscal year.

d. Compliance with procedures established by this policy are subject to evaluation in the context of the USAMEDCOM Organization Inspection Program; Inspector General reviews and Command Site Visits.

FOR THE COMMANDER:

3 Ends

1. RSA Development Flow Chart
2. Financial Performance Report
3. CONOPS Template

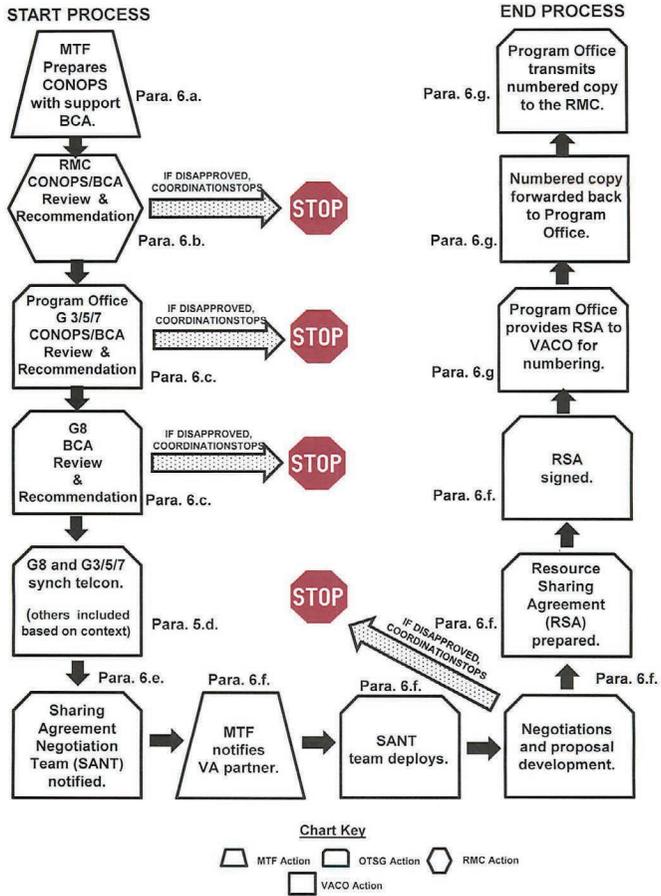

ULDRIC L. FIORE, JR.
Chief of Staff

ANNEX A

The USAMEDCOM Sharing Agreement Negotiation Team

Team Chief – 70A (O5/LTC)
Comptroller – 70C (O4/MAJ)
Facility Planner – 70K (O4/MAJ) - (as needed)
Attorney Advisor – DAC (virtual, as needed)

RSA Development Flow Chart



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Financial Performance - DoD/VA Resource Sharing Agreements (reported quarterly to MEDCOM G8, MCRM-F)							
MTF:							
FY/QTR:							
Accounts Receivable due from the Veterans Administration Office							
Fiscal Year	a. UBO Total Billed \$(000s)	b. UBO Total Collected \$(000s)	c. > 30 Days Past-due from VA \$(000s)	d. % > 30 Days past-due from VA (% of total billed to VA)	e. Plan of Action To Meet Std**	f. Date UBO reconciled with MTF RM	g. Date UBO reconciled with VA for outstanding billings
FY15							
FY14							
FY13							
FY12							
FY11							
FY10							

Standard: GREEN < 6.5%; AMBER ≥ 6.5% ; RED ≥ 11.5%

*For purposes of this report, only JVs or MSSs having ≥ \$1M in annual receivables from VA will submit.

**Use separate page as needed.

Reviewed by RMC DRM Comptroller:

Signature: _____ Date: _____

I ensure the RMC senior leader has been briefed on the content of this report. The Reviewers information is as follows:

Name: _____

Email: _____

Phone #: _____

**DoD/VA Resource Sharing
Concept Of Operations (CONOPS) Template**

1. **Introduction:** This paragraph identifies all of the specific federal sector partner facilities, action officer points of contact and executives. Include complete contact information to include phone, email and mailing addresses.
2. **Market Analysis**
 - a. MTF Posture Assessment. Describe the ability of the MTF to meet access standards for enrolled beneficiaries, as well as the status of recapture campaign targets. Include primary care, specialty care, and inpatient care.
 - b. VA Medical Center (VAMC) Posture Assessment. Describe the ability of the VAMC to meet access standards for enrolled beneficiaries. Include primary care, specialty care, and inpatient care.
 - c. TRICARE Network Posture Assessment. Describe the ability of the network to meet access standards for enrolled beneficiaries. Include primary care, specialty care, and inpatient care.
 - d. PC3 Network Posture Assessment. Obtain VA's assessment of the ability of the network to meet access standards for enrolled beneficiaries. Include primary care, specialty care, and inpatient care.
3. **Mutual and Complementary Needs Assessment.** This narrative will provide a detailed summary of all identified or expected clinical product line matches between each partner facilities' needs and/or excess capacity. Summary will include both volume and type of potential matches between needs and excess capacity.
4. **Concept of the Proposal.** This narrative will describe exactly:
 - a. What each facility would provide in clinical, ancillary and logistical services.
 - b. How elasticity of demand by DoD and VA beneficiaries will be addressed.
5. **Logistics and Staffing.** Provide a detailed description of any anticipated or possible sharing of space, logistics or staffing. Narrative will be supported by a Business Case Analysis (BCA) that demonstrates the precise value of these in-kind contributions.
6. **Information Management and Information Technology.** Provide a detailed narrative on information management, and the secure HIPAA compliant exchange of healthcare information.
7. **Business Operations and Reimbursement.** Provide a detailed narrative on the rules governing authorization and referrals, appointing, coding, billing and reimbursement. Consult MEDCOM G8 as needed; POC Mr Brian Clearman.
8. **Business Case Analysis.** A BCA will accompany the CONOPs that comply with MEDCOM G8 standards for BCAs. POC Mr Kevin Book, MEDCOM G8.
9. **Performance Review Plan.** Provide a narrative description and the proposed metrics to support the annual review of the clinical quality, access, and fiscal performance of the RSA.

APPENDIX C

**Office of the Surgeon General Policy Guidance
on Gratuitous Training Agreements**

This appendix reproduces OTSG general policy guidance on GTAs.

Sent by: ARMY SURGEON GENERAL

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REPLY TO ATTENTION OF

DASG-ZA

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5108 LEESBURG PIKE
FALLS CHURCH VA 22041-3258



2 8 MAR 2000

MEMORANDUM FOR Commanders, Regional Medical Commands

SUBJECT: Mission Essential Skills Augmentation/Enhancement Training

1. You are granted authority to designate certain clinical skills as mission essential for MTFs within your Regional Medical Command, and to enter into gratuitous agreements with local teaching hospitals (with appropriate legal review) so that staff physicians can participate in necessary mission essential skills augmentation, maintenance, or enhancement training. You are also granted authority to allow local MTF commanders to approve staff participation in such training opportunities, as long as the Regional Medical Command has previously entered into a gratuitous agreement with the local teaching hospital involved, and you have designated the training as mission required.
2. While it is recognized that it is the prerogative of each commander to authorize/fund training that is deemed essential for the mission, such training should only be taken in the United States and does not include any overseas training. Additionally, such training should not be any longer than a few weeks at any one time and should not result in additional certification by a recognized specialty or society board.
3. TRICARE access standards must be maintained, and implementation of this authority will not result in overall workload shifts to the managed care contractor.
4. For each gratuitous agreement, issues of licensure, credentials, privileging, and liability must be clearly elucidated to prevent undue exposure of the staff physician or the Army to legal action as a result of participation in training or patient care at those teaching hospitals. The gratuitous agreement must be reviewed and approved by your MTF Center Judge Advocate or assigned staff judge advocate. The standard gratuitous agreements and instructions are attached (enclosures 1 and 2); most of the provisions, e.g., professional liability and reimbursement for services, are mandatory. For civilian facilities that do not have residency/fellowship training programs, the training with industry agreement (enclosure 3) may be more appropriate.

Encs

Ronald R. Blanck
RONALD R. BLANCK
Lieutenant General
The Surgeon General

End 4

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HEALTH POLICY AND SERVICES; Page 17
MEDCON SJA- 703 681 3163;# 5/12

MEDICAL TRAINING AGREEMENT

(AGREEMENT NO. _____)
Installation Code _____

THIS AGREEMENT, entered into on the _____ day of _____ 19____ is between the United States of America, hereinafter called the "Government," represented by the Contracting Officer, and _____ hereinafter referred to as the "Training Institution." It is freely entered into for the mutual benefit of the parties with the understanding that the Training Institution shall provide training to Government personnel at no cost to the Government in return for the services of said Government personnel at no cost to the Training Institution.

1. The _____ Service, _____ (Department) _____ (MTF) conducts a fully accredited training program in _____ (Discipline). The Training Institution trains residents in _____ (Discipline). Under this agreement, _____ (MTF) will assign to the Training Institution, military residents for training in _____ (Discipline) for _____ month periods to supplement the existing _____ (MTF) training program.

2. In consideration of the premises and of the mutual advantages accruing to the parties hereto, this agreement sets forth the duties and responsibilities of all parties, both those of the Training Institution and those of the Government.

3. The _____ (name of affiliating institution) agrees to:
a. Provide professional liability (malpractice) coverage, in amounts that are reasonable and customary in the community for the appropriate specialty, covering liability for personal injury or property damage, including legal representation and expense of defense of any such liability claims, actions, or litigation, resulting from participation by the Army trainees or faculty under this agreement. This coverage may come from any source, but shall clearly cover the Army faculty and trainees while participating under this agreement at _____ (name of affiliating institution) facilities. The source of this coverage shall be _____ (identify the source) and _____ (name of affiliating institution) agrees that if it intends to change such liability coverage

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-> HEALTH POLICY AND SERVICES; Page 18
MEDCON SJA- 703 681 3163;# 6/12

during the tenure of this agreement in a way that will affect the protection provided the Army trainees. Then _____

_____ (name of affiliating institution) will notify the Army in writing, at least 45 days prior to the effective date of the change, specifying the change intended to be made. The _____ (name of affiliating institution) must provide documentary proof of the insurance coverage to the U.S. Army MTF and such documentary proof will be attached to this agreement. The _____ (name of affiliating institution) further agrees

not to seek indemnification from either the United States, the U.S. Army, or the Army trainee for any settlement, verdict, or judgment resulting from any claim or lawsuit arising out of the performance of the Army trainee's professional duties while acting under the control of the _____ (name of affiliating institution) and its employees.

b. To assure compliance with licensure requirements set forth by the medical licensing authorities of the State of _____, for the participation of military residents in the aforesaid training program.

4. It is understood and agreed that on the premises of this agreement, no agent, servant, or employee of the Training Institution shall, for any purpose, be deemed an agent, servant, or employee of the United States Government or be permitted to perform services of any kind on behalf of the United States Government.

5. It is understood and agreed that the education to be furnished military residents in connection with this agreement is gratuitous and voluntary and will be accomplished without cost to the United States Government. The military resident is prohibited from receiving any payment or contribution, including such forms of compensation as meals, quarters, or personal laundry, etc., other than his pay and allowances as a Commissioned Officer of the United States Army.

6. It is further understood and agreed that the military residents, while undergoing training at the Training Institution, will be under the immediate professional supervision and control of the Chief, _____ (Department) at the Training Institution or his authorized designee. All professional services rendered to patients of the Training Institution by military residents will be properly monitored and supervised by Training Institution staff personnel.

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 HEALTH POLICY AND SERVICES; Page 15
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SENT BY:

7. Both the Government and the Training Institution must agree in writing prior to arrival, on the number of military residents who will participate in the training program and on the dates their training is to begin and end.

8. All military residents will be under official orders assigning them to duty at the Training Institution for a specified period of time. Each resident so assigned will first report to the appropriate authority at the Training Institution for appropriate instructions.

9. All residents will be placed under the professional supervision of the Chief _____ at the Training Institution. This official will be responsible for _____ (Department)

a. The quality of training offered the residents at all times.

b. The furnishing of a final written report evaluating the performance of each resident at the termination of his/her assignment. All such reports shall be directed to the attention of the Chief, _____ Service, _____ (Department) _____ (MIF)

10. The duties and responsibilities of each resident participating in this affiliation will be:

a. The workup, evaluation and management of patients assigned to him/her by members of the Training Institution staff.

b. The quality and completeness of clinical records on patients under his/her care.

c. The regular attendance at and participation in all scheduled clinics and any other appropriate teaching conferences at the Training Institution.

d. The assistance at or performance of all procedures as assigned by and under the supervision of qualified members of the Training Institution staff.

e. The consistent performance of duties at maximum capacity.

11. The Chief, _____ Service, _____ (Department) _____ (MIF) will support this training program as indicated and appropriate.

12. It is understood and agreed that the parties of this agreement may revise or modify this agreement by written amendment hereto, provided such revision or modification is mutually agreed upon and signed by the authorized representative of both parties.

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HEALTH POLICY AND SERVICES; Page 20
MEDCOM SJA- 703 681 3183;# 8/12

13. This agreement shall commence on the date of execution and shall continue until terminated.

14. The Government will review this agreement annually before the anniversary of its effective date for the purpose of incorporating changes required by statutes, Executive Orders, or the Federal Acquisition Regulations, such changes to be evidenced by a modification to this agreement or by a superseding agreement. If the parties fail to agree on any such change, the Government may terminate this agreement.

15. Either party may terminate this agreement by giving thirty (30) days advance written notice of the effective date of termination.

IN WITNESS WHEREOF, the parties hereunder have executed this agreement this _____ day of _____, 19____.

THE TRAINING INSTITUTION

THE UNITED STATES OF AMERICA

BY _____

BY _____

(Contracting Officer)

DATE _____

DATE _____

SAMPLE

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MEDCOM SJA* 703 681 3163;# 9/12

MEDICAL TRAINING AGREEMENT

(AGREEMENT NO. _____)
Installation Code _____

THIS AGREEMENT, entered into on the _____ day of _____ 19____
is between the United States of America, hereinafter called the
"Government," represented by the Contracting Officer, and
_____, hereinafter referred to as the "Training
Institution." It is freely entered into for the mutual benefit
of the parties with the understanding that the Training
Institution shall provide training to Government personnel at no
cost to the Government in return for the services of said
Government personnel at no cost to the Training Institution.

1. The _____ Service,

(Department) _____ (MTF)

conducts a fully accredited training program in _____
(Discipline)

The Training Institution trains residents in _____
(Discipline)

Under this agreement, _____ will assign to the
(MTF)

Training Institution, military residents for training in

_____ for _____ month periods to supplement the existing
(Discipline) _____ training program.
(MTF)

2. In consideration of the premises and of the mutual
advantages accruing to the parties hereto, this agreement sets
forth the duties and responsibilities of all parties, both those
of the Training Institution and those of the Government.

3. The _____ agrees:
(name of affiliating institution)

a. Military residents affected by this agreement perform
their training under authority of lawful orders issued by the
Department of the Army and receive their pay and allowances
therefrom. Accordingly, while performing such training, military
residents are acting within the scope of their employment and are
considered employees of the Army acting within the scope of their
employment under Federal law. The provisions of 28 United States
Code, section 2679, will immunize the military resident from
individual tort liability. Furthermore, it is understood by
the _____ that the United States will
(name of affiliating institution)
protect the liability of the military resident only, and that the
United States may, in its representation of the military
resident, assert any defense available under Federal law. Any
notification of an actual or potential claim or suit against the

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which names a military resident
(name of affiliating institution)
as a party or potential defendant will be reported to the United
States Army Claims Service, Fort George G. Meade, Maryland 20755
(telephone (301) 677-7009). The

(name of affiliating institution)
agrees to cooperate fully with the United States in the
investigation of such complaints, to include making available any
medical records, medical material including x-rays, slides,
tissue, and witness statements, and the names of all other
defendants. Further, the

(name of affiliating institution) will
notify the United States of the extent and nature of any
applicable malpractice insurance and whether such insurance
includes the military resident. The United States Army will
cooperate in the investigation and defense of such complaints and
where concurrence of the Attorney General is obtained will, upon
request of the military resident, assist in the removal of the
action to the appropriate Federal District Court with a view
toward substituting the United States as a defendant in lieu of
the military resident.

b. To assure compliance with licensure requirements set
forth by the medical licensing authorities of the State of
for the participation of military residents in
the aforesaid training program.

4. It is understood and agreed that on the premises of this
agreement, no agent, servant, or employee of the Training
Institution shall, for any purpose, be deemed an agent, servant,
or employee of the United States Government or be permitted to
perform services of any kind on behalf of the United States
Government.

5. It is understood and agreed that the education to be
furnished military residents in connection with this agreement is
gratuitous and voluntary and will be accomplished without cost to
the United States Government. The military resident is
prohibited from receiving any payment or contribution, including
such forms of compensation as meals, quarters, or personal
laundry, etc., other than his pay and allowances as a
Commissioned Officer of the United States Army.

6. It is further understood and agreed that the military
residents, while undergoing training at the Training Institution,
will be under the immediate professional supervision and control
of the Chief, _____ at the Training Institution

(Department)
or his authorized designee. All professional services rendered
to patients of the Training Institution by military residents
will be properly monitored and supervised by Training Institution
staff personnel.

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HEALTH POLICY AND SERVICES; Page 23
MEDCOM SJA- 703 681 3163; #11/12

7. Both the Government and the Training Institution must agree in writing prior to arrival, on the number of military residents who will participate in the training program and on the dates their training is to begin and end.

8. All military residents will be under official orders assigning them to duty at the Training Institution for a specified period of time. Each resident so assigned will first report to the appropriate authority at the Training Institution for appropriate instructions.

9. All residents will be placed under the professional supervision of the Chief _____ at the Training Institution. This official will be responsible for _____ (Department)

a. The quality of training offered the residents at all times.

b. The furnishing of a final written report evaluating the performance of each resident at the termination of his/her assignment. All such reports shall be directed to the attention of the Chief, _____ Service, _____ (Department) (MTP)

10. The duties and responsibilities of each resident participating in this affiliation will be:

a. The workup, evaluation and management of patients assigned to him/her by members of the Training Institution staff.

b. The quality and completeness of clinical records on patients under his/her care.

c. The regular attendance at and participation in all scheduled clinics and any other appropriate teaching conferences at the Training Institution.

d. The assistance at or performance of all procedures as assigned by and under the supervision of qualified members of the Training Institution staff.

e. The consistent performance of duties at maximum capacity.

11. The Chief, _____ Service, _____ (Department) (MTP) will support this training program as indicated and appropriate.

12. It is understood and agreed that the parties of this agreement may revise or modify this agreement by written amendment hereto, provided such revision or modification is mutually agreed upon and signed by the authorized representative of both parties.

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HEALTH POLICY AND SERVICES; Page 24
MEDCOM SJA- 703 681 3163:#12/12

13. This agreement shall commence on the date of execution and shall continue until terminated.

14. The Government will review this agreement annually before the anniversary of its effective date for the purpose of incorporating changes required by statutes, Executive Orders, or the Federal Acquisition Regulations, such changes to be evidenced by a modification to this agreement or by a superseding agreement. If the parties fail to agree on any such change, the Government may terminate this agreement.

15. Either party may terminate this agreement by giving thirty (30) days' advance written notice of the effective date of termination.

IN WITNESS WHEREOF, the parties hereunder have executed this agreement this _____ day of _____, 19____.

THE TRAINING INSTITUTION

THE UNITED STATES OF AMERICA

BY _____

BY _____

(Contracting Officer)

DATE _____

DATE _____

SAMPLE

sent by: ARMY SURGEON GENERAL

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Office Symbol

Gratuitous Agreement With Industry
Training With Industry (TWI) Program

Agreement Number:

Contractor:

This Agreement shall remain in effect for a period of _____ . The names of the individuals to be trained will be provided under a separate document reflecting the dates that training is to commence and to be completed within the _____-year period.

Authority for Agreement: 10 United States Code 4301 (a).

Definition: A Gratuitous Agreement, in this case, is a mutually beneficial agreement between a commercial or industrial firm and the U.S. Army, by which a commercial or industrial firm agrees to provide extended on-the-job management training of mid-level Army soldiers for a period of time, usually one year. The Army pays no direct charges for this training, but the training company receives the benefit of the soldier being trained during the period of the training. (See AFARS 37.7204-94).

WHEREAS:

1. The U.S. Army requires that certain military personnel receive on-site training at numerous American industries in management and technological skills, as well as executive level development, as these areas are taught by certain unique industries.
2. It has been determined that the type of training required can only be provided by an extended assignment, usually one year, at the facilities of a commercial firm (hereafter, the "Training Concern").
3. The Training Concern has appropriate personnel, supplies and adequate facilities or other resources to accomplish the training contemplated by this agreement.

NOW, THEREFORE, the parties hereto mutually agree as follows:

Encl 3

1. Syllabus. Within thirty days after the Trainee's report date, the Training Concern shall provide a detailed plan (syllabus) for the training of the soldier in question to the U.S. Total Army Personnel Command (PERSCOM). This syllabus will contain an outline of the training to be provided, as well as a list of necessary travel, per them and other related training expenses. The Training Concern shall state in this document whatever background qualifications or other requirements the prospective Trainee should possess. No training shall proceed without approval of the syllabus by PERSCOM.
2. Academic Report. Within a reasonable period after the conclusion of this agreement, as required by PERSCOM, the Training Concern shall provide PERSCOM with an academic report, as required by Army Regulation 623-1. Academic Reports are prepared on Department of the Army (DA) Form 1059-1, a sample copy of which is provided. Representatives of PERSCOM shall provide guidance to the Training Concern as to the requirements of the Academic Report, and shall have final approval over the adequacy of the report. The Training Concern may add whatever attachments it deems necessary to provide as complete a report as possible to PERSCOM.
3. Provision. The Training Concern shall endeavor to provide the same level and type of training to the Trainee as employees of the Training Concern with similar backgrounds and experience receive.
4. Payment of Travel and Other Expenses. The Department of the Army, through its field agency, PERSCOM, shall provide a limited amount of funding for training-related travel undertaken by the Trainee, subject to the availability of appropriations for that purpose. Once those funds are expended, PERSCOM will consider requests from the Training Concern, on a case-by-case basis, to pay for travel by the Trainee with funds of the Training Concern. These requests will be reviewed to ascertain that the travel in question is essential to the continued performance of the Trainee's primary mission (i.e., training), and that the proposed costs are reasonable. No such additional payment shall occur without the prior permission of PERSCOM. PERSCOM agrees that the Training Concern is under no obligation to fund travel or other expenses of the Trainee with funds of the Training Concern.
5. Liability for Acts Performed Under Training Concern Supervision and Control. It is understood and agreed that the Trainee who is the subject of this agreement shall perform his duties for the Training Concern under the authority of lawful orders issued by the Department of the Army, and shall receive

his pay and allowances therefrom. Accordingly, while performing such training, the Trainee is acting within the scope of his employment under Federal law. As such, the provisions of 28 United States Code, section 2679, will immunize the Trainee from individual tort liability. Furthermore, it is understood by the Training Concern that the United States will protect the liability of its Trainee only, and that the United States may, in its representation of the Trainee, assert any defense available under Federal law. The Training Concern agrees to report any notification of actual or potential claims or suits against it which names the Trainee as a party or potential defendant to the United States Army Claims Service, Fort George G. Meade, Maryland 20755 (telephone: 301 -677-7009). The Training Concern agrees to cooperate fully with the U.S. Army in the investigation of such complaints, to include making available any medical records, medical material including radiographs, slides, and tissue, witness statements, and the names of all other defendants. The U.S. Army shall cooperate with The Training Concern in the investigation and defense of such complaints and assist in the removal of the action to the appropriate Federal District Court with a view toward substituting the United States as a defendant in lieu of the Trainee.

6. Selection of the Trainee. If it chooses to provide a Trainee, the U.S. Army, as represented by PERSCOM, shall select a Trainee with an appropriate background for all training assignments and agrees to the prompt removal of any Trainee whose progress, conduct, or attitude is, in the opinion of the U.S. Army or the Training Concern, unsatisfactory.

7. Compensation and Benefits. The U.S. Army has sole responsibility for the payment of all salary and allowances, including training-related travel expenses in accordance with applicable Federal law and regulations. The Trainee is entitled to all benefits afforded to active duty members, including comprehensive medical care for all injuries sustained in the line of duty. The Trainee is prohibited from receiving any payment or compensation from the Training Concern, including such forms of compensation as meals, housing, personal laundry, and like gratuities.

8. Worker's Compensation. As the Trainee remains the employee of the U.S. Army while performing duties pursuant to this agreement, he or she retains full entitlement to U.S. Army benefits available for injuries arising out of the performance of his or her duties, within the scope of his or her employment. The Training Concern is therefore not required to include the Trainee under its Worker's Compensation Program.

9. Termination. The U.S. Army, by prior written notice of not less than 30 calendar days to the Training Concern, may terminate this agreement, in whole or in part, when it is in the best interests of the U.S. Army to do so. The Training Concern may also terminate this agreement, in whole or in part, by prior written notice to PERSCOM of not less than 30 calendar days when it is in the best interests of the Training Concern to do so.

10. Administration. This agreement shall be administered by the following representative of the Army: U.S. Total Army Personnel Command, ATTN: TAPC-OPB-D, 200 Stovall Street, Alexandria, VA 22332-0411.

11. Assignment and Non-Disclosure Agreements. Any separate agreements concerning assignment of invention rights and/or non-disclosure of "proprietary" information must be submitted to PERSCOM for legal review prior to signature by the Trainee. As the trainee remains a U.S. Army employee during the training assignment, any agreement concerning the assignment of rights in a patentable or copyrightable work is subordinate to the provisions of Executive Orders 1 00096 and 1 0930, as implemented by 37 Code of Federal Regulations Part 501.1 through 501.11 (dealing with the rights to the inventions of U.S. Government employees), or to the provisions of 17 U.S. Code Sections 101, 105, and 403 (dealing with the rights in copyrightable materials prepared by U.S. Government employees in the course of their Federal employment).

12. Publication by the Trainee. Written data relating to the substance of the work done by the Trainee during the Training assignment shall not be published or submitted for publication without the written permission of the Training Concern.

The following individuals certify that they are authorized to execute this agreement on behalf of the Training Concern and the U.S. Government, respectively.

(Industry Signature & Date)

United States Of America
Contracting Officer
& Date

Details of Findings Related to Medical Treatment Facilities

Tables D.1 through D.4 provide further details on the findings from the MTF data call, as described in Chapter Three.

Table D.1
Additional Justification for Military Practice in Department of Veterans Affairs and Other Civilian Facilities

MTF	Service Is Not Provided at MTF	Service Is Provided at MTF, but Patient Volume or Mix Is Insufficient	Service Is Provided at MTF, but Auxiliary Staff Is Insufficient	Retention Incentive	Other
NRMC	2	0	0	0	1
Keller ACH, West Point					x
Ireland ACH, Fort Knox	x				
GAHC, Fort Drum	x				
PRMC	1	1	0	0	0
TAMC, Fort Shafter	x	x			
SRMC	3	2	1	2	1
Winn ACH, Fort Stewart					
Reynolds ACH, Fort Sill	x		x		
DDEAMC, Fort Gordon	x	x		x	x
SAMMC, JBSA–Fort Sam Houston		x			
Blanchfield ACH, Fort Campbell	x			x	

Table D.1—Continued

MTF	Service Is Not Provided at MTF	Service Is Provided at MTF, but Patient Volume or Mix Is Insufficient	Service Is Provided at MTF, but Auxiliary Staff Is Insufficient	Retention Incentive	Other
WRMC	2	0	1	2	1
WBAMC, Fort Bliss			x	x	
Madigan AMC, JBLM	x				
Evans ACH, Fort Carson					x
Bassett ACH, Fort Wainwright	x			x	
Total (of 13)	8	3	2	4	3

Table D.2
Number of Personnel Practicing in Department of Veterans Affairs and Other Facilities, by Corps or Type

MTF	Medical Corps	Nurse Corps	Specialty Corps	Medical Service Corps	Civilian or Enlisted (Training or Care)
NRMC	8	1	1	1	12
Keller ACH, West Point	5	0	0	1	12
Ireland ACH, Fort Knox (new agreement in 2014)					
GAHC, Fort Drum	3	1	1	0	0
PRMC	6	0	0	0	2
TAMC, Fort Shafter	6	0	0	0	2
SRMC	26	0	3	0	13
Winn ACH, Fort Stewart	5	0	0	0	0
Reynolds ACH, Fort Sill	3	0	3	0	0
DDEAMC, Fort Gordon	11	0	0	0	11
SAMMC, JBSA–Fort Sam Houston	5	0	0	0	2
Blanchfield ACH, Fort Campbell	2	0	0	0	0
WRMC	34	1	0	0	1
WBAMC, Fort Bliss	15	0	0	0	0

Table D.2—Continued

MTF	Medical Corps	Nurse Corps	Specialty Corps	Medical Service Corps	Civilian or Enlisted (Training or Care)
Madigan AMC, JBLM	5	0	0	0	1
Evans ACH, Fort Carson	3	0	0	0	0
Bassett ACH, Fort Wainwright	11	1	0	0	0
Total (<i>n</i> = 13)	74	2	4	1	28

Table D.3
Medical Specialties of Physicians Practicing in Department of Veterans Affairs and Other Civilian Facilities

MTF	Medical Corps	AOC or Medical Specialty
NRMC	8	
Keller ACH, West Point	5	Orthopedic surgery, general surgery, podiatry
Ireland ACH, Fort Knox	0	Future: general surgery
GAHC, Fort Drum	3	Obstetrics/gynecology (2), orthopedic surgery (1)
PRMC	6	
TAMC, Fort Shafter	6	Not specified
SRMC	26	
Winn ACH, Fort Stewart	5	General surgery, orthopedic surgery
Reynolds ACH, Fort Sill	3	Orthopedic surgery, otolaryngology, general surgery
DDEAMC, Fort Gordon	11	Family medicine (4), thoracic surgery (3), obstetrics/gynecology (2), plastic surgery (1), neurology (1)
SAMMC, JBSA–Fort Sam Houston	5	Otolaryngology (3), thoracic surgery (2)
Blanchfield ACH, Fort Campbell	2	Not specified
WRMC	32	
WBAMC, Fort Bliss	15	General surgery, orthopedic surgery, obstetrics/gynecology, urology, otolaryngology, ophthalmology
Madigan AMC, JBLM	5	Thoracic surgery (2), obstetrics/gynecology (3)
Evans ACH, Fort Carson	3	Urology

Table D.3—Continued

MTF	Medical Corps	AOC or Medical Specialty
Bassett ACH, Fort Wainwright	9	Internal medicine (4), general surgery (2), psychiatry (2), family medicine (1)
Total	72	

**Table D.4
Medical Personnel Providing Care in Department of Veterans Affairs or Other Facilities as Individuals or Teams**

MTF	As Individuals	On Teams
NRMC	2	2
Keller ACH, West Point	x	x
Ireland ACH, Fort Knox	x	
GAHC, Fort Drum		x
PRMC	1	0
TAMC, Fort Shafter	x	
SRMC	5	1
Winn ACH, Fort Stewart	x	
Reynolds ACH, Fort Sill	x	
DDEAMC, Fort Gordon	x	
SAMMC, JBSA–Fort Sam Houston	x	x
Blanchfield ACH, Fort Campbell	x	
WRMC	4	1
WBAMC, Fort Bliss	x	x
Madigan AMC, JBLM	x	
Evans ACH, Fort Carson	x	
Bassett ACH, Fort Wainwright	x	
Total (<i>n</i> = 13)	12	4

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Army medical professionals must maintain the high level of proficiency required to fulfill the Army's medical missions of supporting military operations and providing beneficiary care. Because beneficiary care demands in a U.S. medical treatment facility (MTF) do not mirror those in a combat setting and sometimes can exceed the MTF's capacity, some MTFs enter into agreements with local civilian facilities to meet shortfalls in beneficiary care or training. The study's objective was to assess Army medical practice in U.S. Department of Veterans Affairs and non-Veterans Affairs civilian facilities and suggest opportunities for improving military-civilian synergies.



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